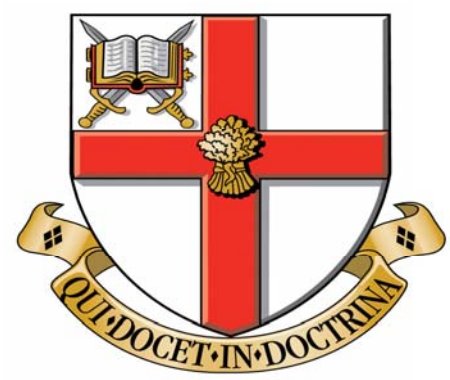

University of Chester

General Practitioner: Understanding Personal Qualities Required to Deliver 21st Century Healthcare from a Business Perspective

Thesis submitted in accordance with the requirements of the University of Chester for the degree of Doctor of Business Administration

by Colin Tate

SEPTEMBER 2013

Dedications

This thesis is dedicated to the memory of my Mum, Sheila Tate, who would have been thrilled to see me achieving my full potential.

Acknowledgments

I would like to thank my primary supervisor Steve Page from the University of Chester who has helped keep my focus on track and who has inspired me to keep going through the tough times. I also wish to thank my second supervisor Professor Caroline Rowland from the University of Chester who prompted me to keep going in my ‘ample free time’.

Thanks are also due to my fellow students Claire Blanchard, Jane Martin, Mark Ward and Roy Williams who have shared this journey and been a great help and support.

I would also like to thank my work colleagues who have encouraged me to complete this piece of work knowing how passionate I am about primary healthcare.

Last and most importantly, love and thanks to my wife Tracy for believing in me, and my children Shelly, Danny, Sam and Vicky for reminding me how proud they are.

Abstract

As a result of the recent NHS reforms following the white paper, liberating the NHS (Department of Health, 2010a), which subsequently became the Health and Social Care Act 2012, it is clear that primary care, led by GPs, face's a considerable change to how healthcare to the population is delivered. Meeting these challenges proves to be difficult due to the nature of primary care contracting, in that GPs are responsible for their own organisations and are required to reconfigure their organisations accordingly. Due to the traditional structure of primary care, GPs appear to lack skills in business management and leadership. The study gains an understanding of the qualities GPs have, and need, from a business perspective, in relation to primary care management, and further develops a qualities framework for use by both current and future GPs. This has been achieved through a qualitative study making use of both structured and unstructured research methods, with the use of thematic analysis drawing meaning from the data. Findings indicate that doctors who have chosen to become a GP tend to not consider their role as business leaders, and opt to learn these skills while on-the-job, although since the implementation of the recent NHS reforms, newly qualified doctors are undertaking business skills training to support their applications for partnership posts. Findings also indicate that GPs see the need to hold business skills as partners within their own organisations as a necessary evil, but see the need to hold these same skills for their membership of the CCG as unnecessarily imposed. A qualities framework has been developed to support GPs with their need to obtain business management and leadership skills, from a general practice perspective. This maps six key qualities across nine domains, measured through a number of competencies for each mapping. It is recommended that the qualities framework developed as part of this research study is applied in general practice in relation to both organisational development and educational strategy. It is anticipated that this will contribute to both general practice performance and improvements in primary healthcare service delivery, from a general practice perspective.

Summary of Portfolio

Following the completion of an MBA degree from the University of Chester in 2009, I felt that to further develop my practice as a senior healthcare manager I would like to advance to a doctorate level degree. Due to my learning style and personal nature, I felt that a structured approach would be more beneficial than being left to my own devices, as is typically seen when completing a PhD. At that time the University of Chester offered their first DBA degree which I duly registered for. One of the first modules completed required a 'Personal & Professional Review' to be undertaken. This was done in the form of a biography which I found to be difficult to carry out, but extremely rewarding. From this exercise it became clear that my career trajectory was going in the right direction, and reaffirmed my enthusiasm for business management and leadership. The module 'Negotiated Experiential Learning' gave me an opportunity to develop my additional passion in GP 'Business and Leadership' education, while gaining a better understanding of the topic within the wider primary care sector, which became a significant element to this thesis. In addition, the module 'International Markets and Marketing' enabled me to touch on the subject of knowledge management, while the module 'Public Affairs' enabled me to consider how reputation affects the NHS, both proving influential elements of this thesis. In order to make sense of the information being collected when reviewing the research topic, the process 'exegesis' which is taken from the 'Global Business Issues' module proved useful when refining this thesis title and structure, supported by the 'Research Methods' modules which grounded my thinking, and which gave the opportunity to develop depth in doctoral level writing and understanding of academic theory. In addition to the structured modules, the shared experiences with peers gave additional depth to discussion linked to theory behind the study programme, again something unlikely to be achieved while undertaking a PhD. As a result of engagement as part of the DBA structure I feel a belonging to the doctoral community, largely through the development of relationships with lecturers within the University, and through the peer group. I believe that the interactive structure behind the course has offered a superior educational experience over other doctoral programmes, and which has supported my academic capability and application to practice, seen through my current activities working within the NHS.

Declaration of Originality

I declare that this work is original and has not been submitted previously for any academic purpose. All secondary sources are acknowledged.

Signed: _____

Date: _____

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List of Abbreviations (Glossary)

AQP	Any Qualified Provider
BAM	British Academy of Management
BMA	British Medical Association
BMJ	British Medical Journal
CAF	Constitutional Advisory Forum
CAQDAS	Computer Aided Qualitative Data Analysis Software
CCG	Clinical Commissioning Group
CMCCG	Central Manchester Clinical Commissioning Group
CMI	Chartered Management Institute
COPD	Chronic Obstructive Pulmonary Disease
CSR	Corporate Social Responsibility
CSS	Commissioning Support Service
DHSS	Department of Health and Social Services
EAH	Empathy Altruism Hypothesis
GAfREC	Governance Arrangements for Research Ethics Committees
GMS	General Medical Services
GP	General Practitioner
GPPO	GP Provider Organisation
HA	Health Authority
HEE	Health Education England
H&SCA	Health & Social Care Act
HR	Human Resources
HSJ	Health Service Journal
LETB	Local Education and Training Boards
LLP	Limited Liability Partnership
LMC	Local Medical Committee
NCB	National Commissioning Board
nGMS	New General Medical Services
NICE	National Institute for Clinical Excellence
NHSE	NHS England
NOS	National Occupational Standards

NRES	National Research Ethics Service
OOH	Out of Hours
PCT	Primary Care Trust
QIPP	Quality, Innovation, Productivity, Prevention
REC	Research Ethics Committee
ROI	Return on Investment
RP	Research Paradigm
RS	Research Strategy
SNA	Social Network Analysis
SS	Social Services
TQM	Total Quality Management
UK	United Kingdom

1 Introduction

1.1 Outline of the Study

Following the passing of the Health and Social Care Act 2012, primary care organisations need to consider their capacity and capability to respond to the intended transfer of many services from secondary care into the community. This transfer of services requires the business leaders ‘GPs’ within primary care to refocus their strategies as, firstly independent contractors, and secondly as members of Clinical Commissioning Groups (CCG). To explore this need further, this study looks through a ‘competencies’ theoretical lens, at how GPs apply their business management and leadership skills, from a general practice perspective, and how education is used to support their business related development.

GP clinical leadership has been well documented in terms of clinical service redevelopment (Abbott, Proctor and Iacovou, 2008; Bowerman, 2006; Checkland, Coleman, Harrison and Hiroeh, 2009; Ferguson and Lim, 2001; Willcocks, 2008), however there appears to be few studies relating specifically to GP business management and leadership skills (Allen, 1995; Gattrell and White, 1996). The study draws on business management and leadership in its broader sense, through a comprehensive review of the literature (Boyatzis, 1982; Clark and Armit, 2010; Mintzberg, 2011; Perren and Burgoyne, 2002).

The study considers current perceived qualities of GPs and develops a qualities framework to aid in their continuing professional development in relation to business management and leadership, from a general practice perspective.

1.2 Background to the Study

The NHS is the largest public sector area under the control of the UK government. The National Health Service Act of 1946 was first introduced by the then Deputy Leader of the Labour party, Aneurin Bevan. However

following much resistance from the medical fraternity, it took until 1948 before the act was enforced as seen in Bloor, Maynard and Street (1999). Since then the NHS has been subjected to many various changes, usually related to government change. The most significant change came in 2010 following the white paper, liberating the NHS (Department of Health, 2010a) and which recently passed through parliament to become the Health and Social Care Act 2012. This was implemented by Andrew Lansley Secretary of State for Health, under the UK coalition government of Conservatives and Liberal Democrats. It is worth noting that parallels can be drawn with the inception of the NHS, as this act has sparked similar resistance to change, during a similar time period of two years, from the same medical fraternities.

Given the new role as a result of the Health and Social Care Act 2012 of ‘financial controller’, primary care GPs must look to new ways of working which will limit any patient perception of withholding services due to budgets, yet meet those budget restrictions in real terms; and from the Department of Health perspective, deliver on the NHS constitution’s main principles, as seen in Department of Health (2012b).

Traditionally primary healthcare management has taken the form of organisational administrators, with strategic support coming from UK government bodies such as Health Authorities (HAs) and Primary Care Trusts (PCTs) with little change since 1948 (Ahmed and Cadenhead, 1998; Ham, Dixon and Brooke, 2012; Laing, Marnoch, McKee, Joshi and Reid, 1997). With the abolition of PCTs, primary care organisations have to up their game managerially, and ensure they have appropriate in-house capabilities for meeting their own strategic needs, while also being aware of how their practice performs within the wider needs of the primary care sector. This is evolving in two forms: general practitioners either taking strategic management responsibilities of their organisation themselves or through the buying in of strategic business managers, while CCGs are taking responsibility for redefining strategy from a commissioning perspective across the wider primary care sector. Meanwhile, with current general practitioner training focusing predominantly on clinical skills, (JRCPTB, 2009), and not

covering to any extent business management, leaving GPs under qualified to meet the demands of the new Health and Social Care Act 2012.

1.3 Specific Purpose of the Research

It is the specific purpose of this research to identify the qualities required of GP leaders in the delivery of primary healthcare as a result of the Health & Social Care Act 2012, by answering the following question:

> ***What management and leadership qualities would enable primary care GPs to deliver "The Operating Framework for the NHS in England 2012/13, and beyond"?***

In addition, the researcher intends to develop a qualities framework which can be used by GPs to further advance their skills in relation to business management and leadership, from a general practice perspective. This is based upon a number of competencies allied to nine domains: analytical ability; developmental capabilities; innovation and creativity; leadership; manage self; quality; shared values; strategist; and working with others. These domains are further articulated by six qualities: behaviour; attitude and belief; knowledge and understanding; performance; self-image; skill and dexterity; and social responsibility, ethics and principles. This framework will be explored further in chapter 4.

In support of this, the study has four objectives designed to direct focus to the appropriate research areas:

> ***"To what extent do GPs consider their future role as business leaders, when choosing to become a GP?"*** *(In terms of what modern communities now expect from them).*
>
> ***"To what extent do GPs consider their education in relation to business management when choosing their future career path?"*** *(In terms of GPs preparation for their future business needs).*

> ***"To understand how the gaining of business skills knowledge would improve the employability of newly qualified GPs?"*** *(In terms of what potential future skill-set requirements may be required by primary care organisations).*
>
> ***"To understand how the gaining of business skills in addition to clinical skills will help GPs deliver future NHS services?"*** *(In terms of what benefits to the NHS could be seen if GPs were able to meet these required skill-sets).*

The outcomes of the study are expected to inform future educational strategies related to primary healthcare delivery, by making sense of future leadership requirements.

1.4 Theoretical Gap & Contribution to Knowledge & Practice

Doctors spend many years studying to become general practitioners due to the complexity and depth required to understand patient healthcare (JRCPTB, 2009). This training covers leadership skills from a clinical perspective, which does offer some transferrable skills to business leadership (Allen, 1995; Balderson and McFadyen, 1994; Ferguson and Lim, 2001; Gattrell and White, 1996), although there remains a perceived gap between organisational management and patient management, and between organisational strategy and healthcare strategy, performed by GPs in particular (Allen, 1995; Balderson and McFadyen, 1994).

Subject to the recent NHS reforms, primary healthcare organisations must work differently. The researcher carried out a number of internet and journal searches which seem to expose an under researched paucity of literature in support of different business models applied to primary healthcare organisations, in terms of change from independent contractor working to federation working and the like. The skill set required to lead these organisations must also be identified, which highlights gaps in GP educational

strategies in support of these different business models, seen at both undergraduate and post graduate levels.

By raising awareness of, and developing a management & leadership qualities framework, in relation to general practice, a contribution to knowledge will be made, with a further contribution to practice through the delivery methods in the use of such a framework. The derived qualities framework should be used in the context of general practice as a provider organisation, covering the functions of management and leadership across the organisation. All individuals involved in management and leadership should be mapped collectively, ensuring all functions are catered for, and which will subsequently highlight any shortfalls. The mapping exercise seen in chapter 4 may also be used for individual personal development plans.

1.5 Overview of Adopted Approach

Owing to the nature of the research study looking to understand meanings of human activities based upon their thoughts and beliefs as described by Mayan (2001, p. 5-6) as seen in Given (2006), the researcher has opted to take an inductive approach rather than the deductive approach. An inductive approach refers to generalisations premised upon an accumulation of observations as described by Harre (1972) as seen in Blaikie (2007), where a deductive approach looks at natural science where laws are used to test hypothesis, as described by Silverman (2000) as seen in Given (2006). The inductive approach fits well with the researcher's intention to make careful observations of human actions while rigorously analysing the findings (Gill and Johnson, 2010).

In support of this inductive approach, an idealist ontology, which represents one's ideals rather than practicalities, has been adopted due to the researcher's understanding that the subject has culture and that the observed hold their own interpretations upon their actions, and that the impression of being real is simply what we think is real (Blaikie, 2007). However, the subtle realist ontology, where one can only know reality from one's own perspective,

was also considered due to it being predicated on the existence of an external social reality, but subsequently dismissed as it became clear the idealist ontology gave a closer fit to the study, due to the idea that the researcher did not want to impose personal opinion on the observed, in gaining a closer insight into their being.

Other ontologies considered were: shallow realist, which was dismissed due to the limitation to observation, as shallow realism suggests there is nothing behind observed events, this also applies to the cautious realist which claims the act of interpretation makes it impossible for humans to understand it accurately. The conceptual realist was also dismissed due to it not being directly observable, and only relating to ideas, whereas the depth realist ontology must explain underlying structures of which this study does not aim to consider (Blaikie, 2007; Given, 2006; Saunders, Lewis and Thornhill, 2012).

According to the researcher's approach, the study of how GPs choose and/or act as business leaders are best considered through the beliefs and theories identified through natural phenomena, and explained through the differences identified in human behaviour. Phenomenology is the strategy of inquiry used to identify the essence of human experiences as described by its participants (Creswell, 2009). Making sense of this phenomenological view led this research into the interpretivism paradigm, further explained in chapter 5 (Blaikie, 2007; Cassell et al., 2006; Creswell, 2009; Saunders, Lewis and Thornhill, 2012). Although the interpretivist paradigm suggests a pure social science approach must be taken, the researcher has made use of numerical data to support the results found from the qualitative methods.

Other epistemologies were considered and rejected such as: empiricism, the theory that all knowledge is based on interactive experience, owing to its use of generalisations of observations and not dealing with meaning of reality; rationalism, the principle of knowledge and reason based actions and opinions, was rejected owing to its need to look for unobservable reality which does not fit with the research aim of taking meaning from reality; falsificationism, which is based upon an hypothesis which must be falsifiable

in order to be scientific, was rejected owing to the invention of theory to account for observations rather than observe and derive meaning; neorealism, a philosophical idea which represents a modified form of realism, was rejected owing to its aim to identify postulations that have not been observed rather than focussing on observation of reality; and conventionalism, which is grounded in fundamental principles behind agreements in society, was rejected owing to its strong relationship linked to its use with natural sciences (Blaikie, 2007; Johnson, Buehring, Cassell and Symon, 2007; Johnson and Onwuegbuzie, 2004).

Underpinning this approach, the abductive research strategy was adopted, chosen due to its fit with the research question type, where a description of understanding is sought from lay accounts, by asking a ‘what’ question. This research strategy looks for the meaning behind reality in the social world pertaining to ‘tacit’ knowledge, which aligns to the aim of the research study, i.e. looking at GP skills (Blaikie, 2007).

Other research strategies (RS) considered included the *inductive* RS which aims to establish universal generalisations in terms of patterns of relationships, which offers some potential to answer the research question, but was rejected due to its limited use of generalisations. The *deductive* RS which tests and eliminates theories, was also rejected due to its incompatible use in answering ‘what’ type questions, and the *retroductive* RS which aims to discover underlying mechanisms used to explain observations, was also rejected due to its need to construct hypothetical models with the aim to establish existence through observation. None of these strategies supported the aim of understanding meaning behind the actions of GPs (Blaikie, 2007; Gill and Johnson, 2010; Johnson and Onwuegbuzie, 2004; Saunders, Lewis and Thornhill, 2012).

1.6 Outline of the rest of the Thesis

The study gains an understanding of the perceived issues related to the research question, through an in-depth review of the literature, followed by a

qualitative research study supported by numerical data, and uses that understanding to develop a qualities framework based upon competencies for use by general practitioners (GPs) in relation to their role as business leaders within the primary healthcare sector.

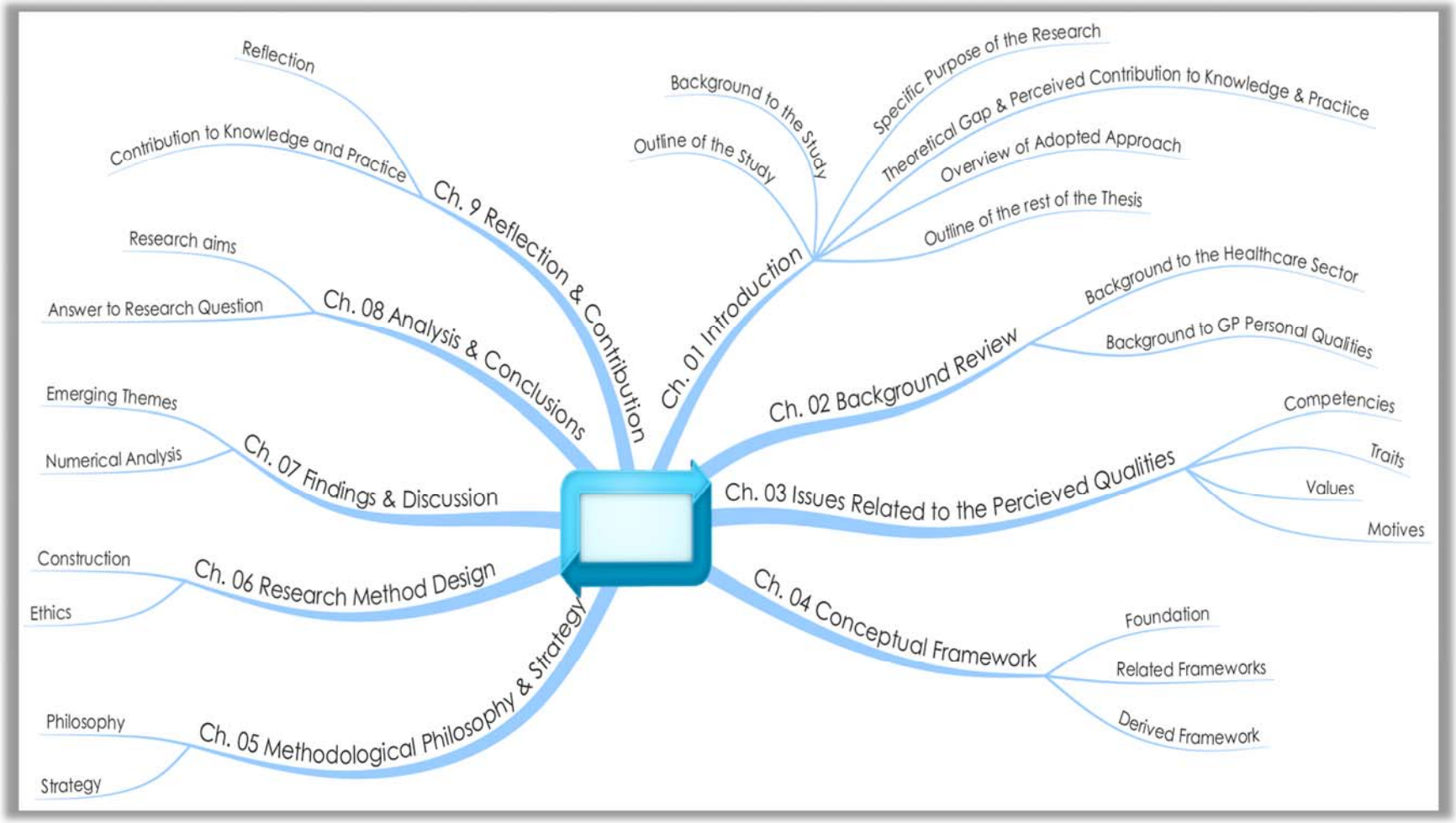
Following this initial introduction chapter the research has two literature review chapters to clearly separate out the distinctly different areas of research: one chapter focusing on an in-depth background review of the healthcare sector and a background view of GP personal qualities, followed by a chapter focussing on the specific issues relating to GP qualities. This helps understand how the step change needed to meet the needs of the operating framework (Department of Health, 2011) may be met.

There then follows a chapter designated to the use and development of the conceptual framework, which pulls together these distinct areas of study and presents them in relation to the needs of the NHS, from a general practice perspective, following the recent passing of the Health and Social Care Act 2012.

Two further chapters are used to describe the research methodology, first looking at the philosophy and strategy, then looking at the research method design, with three further chapters looking at the findings & discussion, analysis & conclusions, and finishing with a chapter on reflection & contribution to knowledge. During the analysis & conclusions chapter the research proposes a qualities framework based upon a number of competencies for use by GPs as providers, both new to the sector and those already established.

The research presents an outline to the development of this thesis through the use of a MindMap™ as seen in figure one below. This shows the key areas, reading clockwise, of each chapter to aid in the visualisation of the whole study.

Figure 1 – Research MindMap



(Researchers own model)

1.7 Summary

This chapter introduces an outline to the whole research project which considers the emerging role of GPs as business leaders within the primary healthcare sector following the recent NHS reforms, and how they may develop their skills to do so through a qualities framework.

By first offering an explanation to why the research is needed, it then discusses the specific purpose of the study, and underpins this with an identification of perceived theoretical gaps and contribution to knowledge and practice. It continues to explain the overall adopted approach and reasons for adopting it.

The next chapter looks more specifically at the background to the healthcare sector and the background to GP personal qualities.

2 Background Review

2.1 Introduction

This chapter introduces the background to the perceived problem, in terms of understanding what NHS management and leadership issues there may be, from a general practice perspective, following the recent passing of the Health and Social Care Act 2012; this aims to transform healthcare delivery methods as a result of the UK's aging population, while also responding to patient expectations. It also introduces related areas which aim to give a better understanding of how GPs may be best placed to respond to these identified issues; i.e. by gaining an understanding of a number of key, yet diverse subjects which underpin them, from social anthropology to educational influences. Gaining an understanding of these problems helps in the development of the general practitioners management and leadership competencies framework, for use in the primary care sector, as seen in chapter 4.

This review of the *'background to the healthcare sector'*, as shown in figure 8, starts with how the public sector operates under the control of UK government; how the Health and Social Care Act 2012 has come about including CCG organisational implications; what this means from a primary care perspective; and the role of patients in the overall delivery of their healthcare. With a review of the *'background to GP personal qualities'* looking at influences coming from education, social anthropology, relationships, psychology and reputation of GPs, which will enable a better understanding of what qualities are required of them when meeting the demands of the NHS Outcomes Framework, as described by NHS Confederation (2011).

2.2 Background to the Healthcare Sector

2.2.1 Public Sector

Managers within the public sector face different challenges than managers from industry. Not expected to maximise profits, they must primarily deal with

the delivery of efficiency and value for money from the resources available to them (Learmonth, 1997). Their funding comes through taxation collected by the UK government who offer a number of public services including the National Health Service. These public services do not trade on income revenue: they are allocated fixed budgets paid for by that taxation (HM Treasury, 2010), which suggests that management of these budgets financially restricts the outcome quality deliverables of that service, leaving the '*delivery methods*' alone to account for any improvement in achievable quality (Verbeeten, 2008). Furthermore in their paper on resource dependency theory, which is the study of how organisational behaviour is affected by external resources, Ghobadian, Viney, and Redwood (2009) argue that the key stakeholders of public sector organisations are not as expected, the public; the key stakeholder is in fact the government. This leads them to think that managers tend to prioritise government interests over the interests of the beneficiaries of those services. However, this is at odds with the new Health and Social Care Act 2012, one of the UK's main public sector areas, as the main purpose of the NHS, according to the legislative framework, liberating the NHS, states that there should be *"No decision about me, without me",* (Department of Health 2010b), so clearly putting the end-user at the heart of any NHS activities. This indicates a management dilemma in terms of who healthcare leaders should regard as the key stakeholder: patients (public) or government.

Management and Leadership frameworks, used in the public sector, must overcome the dilemma of stakeholder management, in the first instance, if it is to be of any use to future public sector leaders (Clark and Armit, 2010; Proctor and Campbell, 1999; Tate, 2013). The seven principles of public life, known as the Nolan principles as seen in appendix one, goes some way to give direction to public sector managers behaviour with this conundrum, but does not answer the specific issue. Ghobadian, Viney, and Redwood (2009) continue to discuss the unintended consequences of recent health care reforms and suggest that, in the case of these reformed public services, the interests of government as both the commissioner and funder of services adds a further level of complexity to this issue, that it is the intention to put the

end-user first, but unintentionally government is put first. In terms of the NHS, from a general practice perspective, managing this balance between end-user and government will now become the direct responsibility of primary care GPs; a difficult one for them to manage as suggested by Ham, Dixon and Brooke (2012).

2.2.2 Health & Social Care Act, including CCGs

It has become widely accepted that the UK has an ageing population, and as a consequence that population comes with an increase in chronic disease areas such as dementia, obesity, diabetes, and chronic obstructive pulmonary disease (COPD) among others, (Department of Health 2011; Ham, Dixon, Brooke, 2012; HM Government 2010). As a result of this, the UK government under the Secretary of State for Health, Andrew Lansley MP, has implemented the Health and Social Care Act 2012 to help ensure that in the future this ageing population is catered for. However, due to the far reaching measures included in this act it received much opposition from existing medical professional bodies, so much so that the parliamentary review process was ‘paused’ (http://www.number10.gov.uk/news/government-launches-nhs-listening-exercise/) for an independent review of key stakeholders views, culminating in a number of areas being re-written. Further controversy came about during the summer of 2012, when the Prime Minister David Cameron replaced Andrew Lansley MP as Secretary of State for Health with Jeremy Hunt MP (http://www.bbc.co.uk/news/uk-politics-19472688).

The act itself has the following top five key strategic points as listed below, (Department of Health, 2010b):

- To uphold the existing values and principles of the NHS
- To put patients and the public first
- Improve healthcare outcomes
- Empower professionals with autonomy, accountability and democratic legitimacy
- Cut bureaucracy and improve efficiency

These strategic points are widely accepted; however there is much opposition stemming from the underlying assumption that much of the NHS will be privatised as seen in Pollock (2011) with many of the back office functions being passed to the private sector, which then may also be seen to fall out of these strategic points, in terms of outcomes measurements.

As part of the operating framework (Department of Health, 2011), NHS organisations must prepare for the health and social care reforms from both a commissioning and provider perspective. The change in the commissioner's landscape includes the abolition of Primary Care Trusts (PCT) in favour of Clinical Commissioning Groups (CCG). CCG's are taking shape across a smaller footprint than the outgoing PCTs, typically with a mean value of approximately 280,000 patients compared to a PCT mean value of around 365,000 patients (Wood and Ward, 2011), with these organisations being led by a board comprising of practising GPs, with a small number of public sector managers. The change in provider landscape sees the additional emergence of Commissioning Boards (http://www.commissioningboard.nhs.uk/) which replace the provider functions formerly carried out by PCT's; more recently known as NHS England. This board's main responsibility is to administer provider contracts, as there would be an obvious conflict of interest if the new CCG's, made up from local providers, i.e. GPs, were to commission themselves. GPs must remain conscious of their opposing roles within primary healthcare, firstly as providers under contract from NHS England, and secondly as members of CCG's.

The operating framework (Department of Health 2011) is underpinned through the NHS constitution which is renewed every 10 years, and establishes the principles and values of the NHS in England (Department of health 2012b, p. 2). A statement taken from the constitution is shown below.

> *"It sets out **rights** to which patients, public and staff are entitled, and **pledges** which the NHS is committed to achieve, together with **responsibilities** which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively".*

There are seven principles and six values that guide the NHS constitution, as seen in appendix two; however individual organisations are empowered to further develop their own local set of additional values based upon these (Department of health 2012b; Songailiene, Winklhofer, McKechnie, 2011).

The NHS operating framework (Department of Health 2011) is designed to drive change and deliver outcomes through quality improvement. A number of outcomes measures have been identified and presented in the form of five domains:

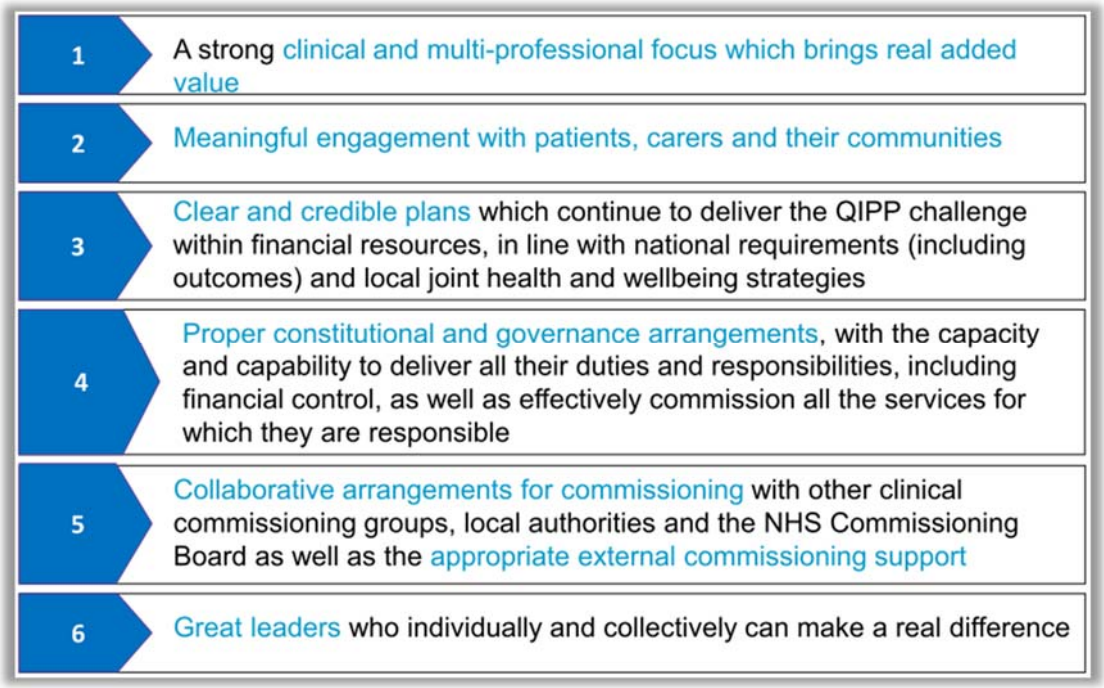
1. Preventing people from dying prematurely.
2. Enhancing quality of life for people with long term conditions.
3. Helping people to recover from episodes of ill health or following injury.
4. Ensuring that people have a positive experience of care.
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Improved outcomes from these five domains can be illustrated though the Quality, Innovation, Productivity and Prevention (QIPP) challenge, which aims to deliver real quality and productivity improvements. Meanwhile, during the transitional period prior to CCG authorisation, appropriate investment in public health must be maintained (Department of Health, 2010c; HM Government, 2010; Storey and Holti, 2013).

Given the operating framework sets out to fulfil the new scope of the Health and Social Care Act 2012, the framework has been accepted by leading industry organisations, who confirm that the additional outcome measures present a genuine opportunity to deliver better healthcare for patients, although concerns are raised in the need for additional investment in the key area, which underpins almost all other areas: that of data collection/information governance, of which GPs are patient data controllers, and which are still largely unresolved (NHS Confederation 2011).

Robust development of Clinical Commissioning Groups (CCGs) is achieved through the Department of Health authorisation framework which has 6 domains, as seen in table 1 below (Department of Health 2012c).

Table 1 – Authorisation Domains



These six domains are delivered via a clinical commissioning board made up from a majority of clinical leaders with lay members including hospital doctors, nurses and executive members (PriceWaterHouseCoopers, 2010).
High expectations have been set for CCGs, as commissioners of primary medical care who commission to meet patient needs. They are key in supporting and facilitating the change to the new structure of primary care commissioning as detailed in the White Paper, Equity and Excellence, (Department of Health. 2010b) while continuing to aim for £20 billion quality and productivity savings by 2014/15. Building on what Ham, Dixon and Brooke (2012) argue, since their inception PCTs have fundamentally changed how they have commissioned primary care, creating greater transparency, rigour and active management of primary care. At the same time they have developed an understanding of the value achieved from their investment in primary care services and continue to achieve shifts in the way care is delivered across the health service. They continued to do this whilst

supporting the emerging Clinical Commissioning Groups (CCGs) in developing their new role.

In support of these developments, from a CCG perspective, Commissioning Support Units (CSU's) have been employed to aid in the management function of, among others, finance, IM&T and business intelligence. However, it could be argued that this is the first step in the privatisation of the NHS (Pollock, 2011; Wood and Ward, 2011) given that CSU's will become private entities in April 2015. General practice however, does not have the support of CSU's or equivalent for management services, and it now becomes the responsibility of GPs to meet these needs.

In addition, following the passing of the Health and Social Care Act 2012, and the development of Clinical Commissioning Groups and NHS England, primary responsibility for health improvement and health protection will transfer at national level from the NHS to Public Health England, and at local level from PCTs to local authorities. Responsibility for strategic planning and commissioning of NHS services will transfer to NHS England and to Clinical Commissioning Groups. This is seen as a clear attempt to bring together the healthcare sector with social services as noted by Ham, Dixon and Brooke (2012), which will remain an additional challenge for Clinical Commissioning Groups to overcome, and for primary care organisations to deliver upon.

2.2.3 Primary Care Management

Prior to the launch of the NHS in 1948, general practitioners traditionally ran 24 hour healthcare services from their homes while making use of their wife/house keeper as receptionist-come-financial administrator (*no sexism is implied*) as seen in Westland et al. (1996). Seen as a cottage industry, GPs relied on their colleges, such as the British Medical Association (BMA), to help with developments in the sector, including best practice methods as seen in Laing, Marnoch, McKee, Joshi, and Reid (1997) who continue mapping the evolution of general practice, through the creation of partnerships, to multi-skilled health centres in the 1990's as seen in appendix three, where GPs

have also come to accept that practice management is not a simple book keeping task, but is an essential skill in modern day health service delivery.

The role of general practice has since developed even further and most importantly in 2004, following the agreement by the British Medical Association (BMA) to the new General Medical Services (nGMS) contract, (Department of Health, 2003), where this contract relieved general practitioners of their duty to offer 24 hour care to their registered patients. This introduced the out-of-hours (OOH) service who would see these patients on behalf of the general practitioners through the evening, night and weekends. In addition the contract offered GPs additional income based upon the Quality Outcomes Framework (QOF); a quality initiative where GPs would receive additional income based upon their achievement of clinical outcomes.

However in return the nGMS contract lays out strict organisational expectations which includes the close monitoring of staff roles, of which practice management is noted as being *“a critically important function”* (Department of Health, 2003, p. 104). The nGMS contract continues with the following statement:

> *Practice managers will have an increasingly important role as they become the experts in the operation of the new contract, including all the new mechanisms outlined in this guidance.*

This clearly puts practice management at the top of primary care organisations, and heavily involved in any future strategic developments. In support of this Warwicker (1998) suggests that central government aim to increase their hold over general practitioners powers through such managerialist initiatives; however Learmonth (1997) asserts that, paradoxically, managers are increasing their influence in the NHS albeit to increased criticism from the general public; suggesting the focus of the NHS is moving from clinical to administrative.

Some general practitioners (from within both partnerships and single handed practices) prefer to retain the mantle of lead manager while giving the title ‘practice manager’ to lead administrators for contractual purposes, which suggests that many GPs are unhappy to hand over control of their organisations; however this then requires them to hold skills in both clinical care and management. As such, some GPs have undertaken additional management qualifications while many have simply learnt on the job, (Allen, 1995; Gattrell and White, 1996; Ong and Schepers, 1998), and to varying degrees of success.

Abbott, Proctor and Iacovou (2008) identify three management engagement mechanisms: Separation, Alliance and Integration. Where they suggest that ‘Separation’ characterises the relationship between most GPs and their governing authorities from a contractual perspective; Alliance referring to arrangements between multiple primary care organisations in the form of GP commissioning pilots or locality groups; Integration referring to how PCTs, and more recently CCGs, function with primary care organisations, in terms of service delivery. From these mechanisms, it appears that Alliance has proved to be the most successful when planning local initiatives. However, Abbott, Proctor and Iacovou’s (2008, p. 433) research concludes that:

> “*the NHS lacks organisational arrangements which permit GPs a primarily clinical focus while ensuring that their knowledge and advice is available to those carrying out administrative functions*”.

They continue to conclude that *“Practice-based commissioning may provide a means of improving such arrangements*”.

This may well be resolved through the forming of Clinical Commissioning Groups (CCGs), which are now taking shape in order to manage primary healthcare services, led by clinicians, where clinicians includes not only GPs but also includes nurses and associated healthcare professionals, such as hospital doctors (Department of Health, 2012b). This emerging development of ‘clinician led’ healthcare must come with a warning; that the function of

'management' must continue to play a significant role if the underlying requirements of: budget management, human resources (HR) and process management, to name a few, can continue to be met. Those clinicians who take leadership posts in the new NHS should ensure they also develop their management skills (Balderson and MacFayen, 1994; Gatrell and White, 1996; Grimshaw and Youngs, 1994; Holden and Spooner, 1995; Ong and Schepers, 1998; Parayitam, Phelps and Olson, 2007).

2.2.4 Patients

Many elderly patients still remember their relationships with their GPs both during the pre-war era and just after the war, where patients were expected to demonstrate gratitude for any care the GP was able to offer (Bloor, Maynard and Street 1999). Some suggest the term '*patient*' derives from these early consultations, where sick people were expected to sit and endure under strain '*patience*', awaiting for the GP to see them when possible, as seen in (Patterson, 2003); however the correct meaning is derived from the Latin word '*patiens*' meaning '*I am suffering*' (Patient, 2010). Remnants of this early relationship can still be seen today, where many elderly patients prefer to call their GP 'doctor' as opposed to the younger generation who feel comfortable calling their GP by their first name (Razzouk, Seitz, and Webb, 2004). This cultural change impacts upon development of both the reputation of the GP and their core values (Keaney, 1999).

Much of this change can be attributed to political involvement, where the NHS has been used to nationally measure public satisfaction (Department of Health, 2012d), and as a result, played with during election campaigns for votes. Many promises have been made, but one continuing trend has been the move from government 'offering' a healthcare service during the 1950s to patients 'demanding' a healthcare service during the 2010s. This can be seen through the impact of the recent social and policy changes which have been described as the "de-professionalisation" of the doctor-patient relationship (Elston, 1991) as seen in Murie and Douglas-Scott (2004), and can be further demonstrated through national patient satisfaction surveys as seen in

Department of Health, (2012d) which shows little improvement in GP satisfaction although there has been a clear improvement in clinical outcomes (Sajid and Baig, 2007).

This patient demand requires a new management focus: that of patient satisfaction, where Swinehart and Smith (2005) suggest the use of Total Quality Management (TQM) methods. The TQM movement is concerned with reducing all known and unknown failures while continuously improving delivery of high quality products and services (Slack, Chambers, Johnston and Betts, 2009). These could be used to allow for a rapid improvement in the assessment of patient satisfaction, with Murie and Douglas-Scott (2004) expanding this idea further following their five years' experience of patient and public involvement in primary care, where positive outcomes reported have consistently been used as an effective dialogue between health professionals, patients and the public, service developments and quality improvements. However Anton, McKee, Harrison and Farrar (2007) suggest that there remains an uncertainty and a lack of consensus about how the assessment of any public involvement should be carried out, following the recognition that public involvement is a diverse area and would require flexibility when being administered at a local level. This local level approach is reinforced by Sajid and Baig (2007) who suggest that patients add value when assessing healthcare system outcomes leading to a patient responsive system, and which is especially important when the provision of best quality health services to patients is a difficult task, especially when NHS budgets are being cut and jobs are being lost.

In order to improve patient and public engagement, Ahmed and Cadenhead, (1998) explain that there have been many attempts to build and improve patient engagement, although they argue that any engagement is another step forward in recognising the importance of the patient in the NHS. This is demonstrated through the following recent legislative framework statement that there should be *"No decision about me, without me",* (Department of Health 2010b, p. 5), a further clear message that the UK government wish the public to fully engage with, and take ownership of their own healthcare. This is

further supported by Keaney (1999) who argues that far from being a passive consumer of pre-packed healthcare, patients ought to be considered as partners in a continuing process of inquiry, in accordance with John Dewey's philosophy of instrumentalism, as seen in Keaney (1999). Instrumentalism is described as observed phenomena in terms of analytical fit to results and evaluation (Dewey, 1977). As a point of caution, it is also worth noting that industry has spent a considerable amount of effort in understanding customers, so much so that Dixon, Freeman and Toman (2010) identified that companies that went above and beyond in their customer service delivery became so entrenched in the process that their managers rarely examined it. A further study of more than 75,000 customers interacting with contact centre representatives or using self-service channels found that over-the-top efforts made little difference to customer loyalty; all customers (or in terms of the NHS, patients) really want is a simple, quick solution to their problem. Primary care strategic plans should demonstrate that the role of the patient, and their relationship with their GP to be symbiotic with the organisation’s shared values (Mitchell and Imrie, 2011).

As the new Health and Social Care Act 2012 comes in to force, GPs who all have a role as both providers of healthcare through the running of their general practice, and commissioners through participation with their clinical commissioning groups, are put in a position where they need to recognise that patient engagement and participation is crucial to meeting patient demand, but also have a responsibility to taxpayers to look for value for money and efficiency; this brings in to question clinical ethics, although GPs are not new to managing allocated funds, and routinely make judgements about referring patients for further treatment. There are four principles deemed helpful when considering ethical commissioning: autonomy, in terms of taking responsibility for the governance of one’s own life; beneficence, in terms of balancing treatment against risks and costs in favour of the patient; non-maleficence, in terms of avoiding unnecessary harm to patients; and justice, in terms of distributing benefits, risks and costs fairly, as described by Oswald and Cox (2011). This is useful when making decisions that impact on the health of the population which requires justification not only on the grounds of cost

effectiveness and efficacy but also in terms of justice (Oswald and Cox, 2011). Drawing on the existing patient participation and engagement activities already in place, GPs and CCGs may well find it useful to include patients with these decisions through fair and open processes.

2.3 Background to GP Personal Qualities

2.3.1 Social Anthropology

Culturally, it can be argued that General Practitioners typically belong to social groups that share similar influences and who are driven towards their career paths by vocational needs (Fones, Kua and Goh, 1998). An unrelated study by Shankarmahesh (2006) suggests that ethnocentrism, which refers to the evaluation of other cultures based upon the presumption of one's own culture, has four main antecedents: socio-psychological, political, economic and demographic, although in terms of judging another culture by its values and standards these antecedents can be applied to GP social groups. Ingham (2007) argues that human behaviour is complex based upon cultural differences and social contexts, which can be characterised through network theory, a certain mechanism and process that interacts with complex structures to yield certain outcomes for individuals and groups, where Borgatti and Halgin (2011) discuss the use of network theory further and suggest two outcomes: firstly 'choice' which includes behaviours, attitudes, beliefs and structure; and secondly 'success' which includes performance and rewards. The first outcome 'choice' fits with Shankarmahesh (2006) antecedents where socio-psychological aligns to attitudes; political and economic align with beliefs; and demographic aligns with structure. The second outcome 'success' draws on capability which can be measured through earnings and status. However, as discussed in the previous section, there appears to be a "de-professionalisation" of the doctor-patient relationship (Elston, 1991) as seen in Murie and Douglas-Scott (2004) which may have future implications on their status, and upset this outcome. For the GP profession to retain its appeal, 'choice' and 'success' outcomes need to be retained when developing future leadership roles.

Such social groups could be deemed tribal, insinuating the same collective set of behaviours, attitudes, beliefs and structure as seen in Borgatti and Halgin (2011) need to exist among the group as suggested by Mitchell and Imrie (2011) who also extend the view that emergent tribes require a complete understanding of the antecedents and roles implicit within tribal membership relating to the tribe's social behaviour, membership role and influence on individual participation. They further suggest that tribes require a core set of values that moderate any individual differences. In addition to the four antecedents as seen in Borgatti and Halgin (2011) a fifth role of 'Chief' has been identified by Cova, as seen in Mitchell and Imrie (2011) which was found to act as an opinion leader and organiser amongst the group.

Currie (1996) further describes how tribes (healthcare clinician-managers) are encouraged to unite through the use of business values and associated behaviours; however these local antecedents may not fit with the wider healthcare landscape (choice) and therefore introduces conflict when clinician-managers are required to choose their NHS group membership.

Logan (2009) describes five stages of tribes: stage 1 relates to the culture of 'gangs', perceived as the very basic of stages, typically reserved for the less well educated; stage 2 relates to the culture of 'standing in line', something we all do intuitively but can be argued as acting 'dumb'; stage 3 is the bulk of the human race where one feels that they are better than another in a form of competition, such as claiming their car is better than another's or they earn more money than another; stage 4 is where individuals come together as united in whatever their tribe believes in; and stage 5 being the pinnacle of the stages, where the whole tribe have come together based upon their values and with a shared aim to achieve their ultimate cause. It is therefore argued that GPs should aim to meet stage 5 of tribal membership, while retaining clear understanding of their 'choices' leading to an acceptable level of 'success'; while also meeting the needs of primary care, as laid out in the H&SCA (2012) through collaboration and federation within their communities/localities.

Having gained an understanding of culture and tribal influences, GPs need to find ways of communicating across boundaries where Lewis (2012) suggests this is linked with the concept of work-role transition and with the micro-politics of organisational behaviour. However this should be carried out with caution, as the role of power against disillusionment needs to be kept in balance; according to Covey (2004) one should always look for the win-win, so neither party has to be the loser. In addition Atkin and Hassard (1998) developed the notion of 'communal belonging' for assessing social solidarity across local institutions and boundaries, which underpins Armour's (2002) suggestion that a lack of societal knowledge increases the number of social problems. Gray (2006) examines the relationships between social, environmental and sustainability in relation to shareholder value, and suggests that due to financial capitalism there is an erosion of social justice, and as such GPs will need to find new ways of developing inter-organisational relations. This may be achieved through psychological contracts as seen in Pesqueux (2012) who suggests the concept of contract is about will, agreement, obligation, promise, commitment, staying true to one's commitment, cooperation and bond, which links the contract with sociality, based upon both the anthropology of the individual and the anthropology of the contract. The concept of social justice must relate back to one's tribal values which may be achieved through frameworks as seen in Capper, Theoharis and Sebastian (2006) which aims to prepare leaders in their delivery of social justice. In terms of GPs, they need to develop psychological contracts for both their commissioning role and their provider role, in such a way as to not compromise either contract, and in addition these contracts must align with their underpinning values as shared across their tribe/social group.

2.3.2 Education

The role of a medical doctor is primarily based upon medical science, where an understanding of, among others, human physiology and anatomy has been gained. These skills allow that medical doctor to restore health following a diagnosis of disease or injury, (Longlett, Kruse and Wesley, 2001). The core underpinning qualities of a medical doctor are therefore premised on the study

of science subjects. Those medical doctors who, within the UK National Health Service, choose to specialise as a GP (General Practitioner) require further skills that allow that GP to treat acute and chronic conditions while providing primary preventative care and health education (Wilson and Holt, 2001); relying further on their earlier study of science subjects. Due to the contract status of the UK National Health Service; when undertaking the role of a GP, many have traditionally also engaged themselves in the role of business person through their agreement to become a practice partner or single handed GP; requiring a need to draw on a different study path, although not necessarily realised, (McClelland and Jones, 1997).

van der Velden (2012) questions, in early year's education, whether it is right to compare one type of learning that leads to specific results with another type of learning that may lead to a broader agenda. More specifically she questions whether successful teaching arrangements that lead to annually improving A-level results are appropriate for later university study, where the ultimate aim is to promote independent, critical and continuous learners. In terms of aspiring medical doctors, many have not yet chosen to become a GP; and their intellectual explorations must continue later in their career paths and align with new skill sets not yet considered. This suggests that given the wherewithal to become a critical thinker throughout one's education, one will be able to adjust to new demands as they arise. Future educational strategies, in terms of healthcare, must be mindful of these likely demands upon general practitioners as they embark on their career paths.

One way of achieving such an educational strategy can be seen in, Liberating the NHS: Developing the Healthcare Workforce, Department of Health (2012e), where the UK government propose the creation of an autonomous education board. This board, the HEE (Health Education England), will ensure high quality education that supports innovation, value for money, and improved skills development, which will bring together existing healthcare providers, the professions, patients and staff; although this does not make clear how links to earlier educational institutes will be developed to promote innovation and entrepreneurship. Furthermore, in terms of general practice,

this still does not account for the development of '*independent*' service providers, such as GPs who are engaged under a contractor status (Checkland, Harrison and Marshall, 2007). It is therefore assumed the responsibility of that small business unit (general practice) to develop their own services; which is expected to lead to innovation and service improvement; or may not, (Checkland, Coleman, Harrison, Hiroeh, 2009; McDonald, Harrison, Checkland, 2008; Storey and Holti, 2013). The UK government's efforts to develop an educational board must find ways of including both educational institutes and contractor status developments within their plans to ensure that in real terms primary care innovation is, and can be realised.

Contemporary involvement of doctors in management, as discussed in McClelland and Jones (1997) has identified a provocative and intense debate among clinicians and academics. Where they suggest that previous attempts to involve doctors in management date back at least to the Cogwheel Reports of 1967-1969 (Thompson, 1993) as seen in McClelland and Jones (1997). They highlight the debate undertaken by Sir Roy Griffiths in 1983 relating to the introduction of general management following the Management Enquiry, which states (McClelland and Jones, 1997, p. 335):

> *The nearer the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the natural managers (DHSS, 1983).*

However, 25+ years later this still needs to be accepted by clinicians, as they continue to perceive their role to be primarily clinical (Huby et al., 2008). The growth in managerial responsibilities assigned to clinicians (Thompson, 1993) as seen in McClelland and Jones (1997) has led to claims that doctors are still unprepared for such new adventures. With the onset of the Health and Social Care Act 2012 the issue still remains of the need for and scope of education, training and development and whether this should be part of an undergraduate/pre-registration programme or as part of a post-qualification training period (Eaton, 1994; Orchard, 1993) as seen in McClelland and Jones

(1997). Although Adcroft, Willis and Dhaliwal (2004) discuss some growth in management education generally, and entrepreneurship education specifically, which has occurred at the same time as increasing importance is attached to management both as an activity for academic investigation and as a practical activity in both public and private sectors. Adcroft, Willis and Dhaliwal (2004) continue to argue that the intellectual underpinning of this growth is unsupported by a significant amount of evidence and so it is unlikely that the expected economic outcomes will be achieved. In the specific case of entrepreneurship education, they recommend that the tension between prescription and recognition of the activity needs to be resolved by both academics and policy makers before the benefits of education in this area can be realised.

The then Secretary of State for Health told the June 1994 conference of the British Association of Medical Managers that she wanted “more doctors in management” and she wanted “doctors managing to be as commonplace as doctors teaching”, although this comment does not specify if it relates to general practitioners, and/or whether general practitioners are expected to develop their own management skills. However GPs continue to see management and organisational development as somebody else’s job, with uptake currently perceived at low numbers (Huby et al., 2008; McClelland and Jones, 1997; McDonaln, Harrison and Checkland, 2008). However, in support of management and organisational training there are a number of frameworks currently available, such as the “New NHS Leadership Framework”, as seen in Institute for Innovation and Improvement (2011), which offers seven areas as seen in appendix four, but still does not promote the need for GPs to embrace their position as business leaders in addition to their role as clinicians, and encourage them to make use of this position to innovate and develop better services.

Some of the constraints and opportunities currently facing the NHS may well be resolved through management training and development activities aimed at both managers and doctors, as suggested by Gatrell and White (1996). Specifically, management development for doctors is seen as patchy across

the UK, with certain areas offering such training in conjunction with specialist support functions, and key personnel driving the change. Gatrell and White (1997) further suggest that there is a 30:70 split between doctors in support of management training and those against, although the undergraduate curriculum has made attempts at delivering the ‘softer’ skill development, it is largely thought that there has been little change. Senior doctors have shown an interest in management training only where there was a perceived relevance to their clinical work, even though both GPs and hospital consultants have been noted as over-rating their own skills in comparison to junior colleagues, (Gatrell and White, 1997). If the work of Liberating the NHS: Developing the Healthcare Workforce (Department of Health, 2012e) is to come to fruition, the HEE will need to engage with GPs from a business perspective to find ways of developing doctors in management.

2.3.3 Relationships

Sholten and van der Grinten (1998) describe that one of the constants in Western healthcare has been the problematical relationship between clinicians and management. They suggest that medical specialists and hospital managers, in particular, have a love-hate relationship. They further suggest that this is particularly pronounced in the UK, initially following the recommendations of the Griffiths Report of 1983, which introduces general managers at each level within the NHS. And which has been developed further within the primary healthcare sector following the introduction of the new General Medical Services (nGMS) contract, (Department of Health, 2003), which highlights practice management as a key driver for meeting the demands of the contract. Sholten and van der Grinten (1998) further discuss similar relationship developments across the USA, Germany and The Netherlands, whose relationships are influenced by finance; to varying degrees. Parallels can now be drawn following the introduction of the Health and Social Care Act 2012 which aims to drive innovation from within the primary healthcare setting as previously identified by Hurst (2006); which is predominantly run under contractor status and which aims to further close the gap between the clinician – manager role for GPs, although the context

becomes more complicated due to conflicts of interest, through their role as member organisations belonging to the commissioning arm of the NHS, who in turn commission primary care services. Although there is a general acceptance of key values such as accessibility to high quality health care, free at the point of delivery (Department of Health, 2003), and linking this to the emergence of primary care led initiatives including social entrepreneurship, there will continue to be challenges for such substantial relationships to be developed. However, Merali (2003) identifies common views, beliefs and attitudes between clinicians and managers, in terms of altruistic core values, and suggests that these are paramount in the effective and successful implementation of these current reforms.

It has been suggested by Young (2006) that personal relationships interplay with motivation, emotion and cognition, but are limited by costs and environment, which may give some understanding to clinician – manager relations. It could be argued that both share the same motivation (delivery of healthcare), emotion (appreciation and satisfaction) and cognition (benefits realisation), leaving costs and environment as potential conflicting factors in their relationship, and very confusing to GPs who are undertaking both roles. Costs may well be seen as an imposition to clinicians, yet seen as a target by managers, and environment seen as the norm by clinicians, yet seen as a driver for change by managers (Young and Daniel, 2003) as seen in Young (2006). For these issues to be overcome, clinicians and managers must analyse how relationships can be managed based upon the factors involved such as, organisational in terms of structure, relational in terms of job function, spatial in terms of job role, and network in terms of social groups, albeit within the context under which they are operating (Veludo, Macbeth and Purchase, 2006).

Goyal and Akhilesh (2007) have termed ‘cognitive intelligence’ in terms of learning, ‘emotional intelligence’ in terms of intra and interpersonal intelligences and ‘social capital’ in terms of institutional dynamics as the key determinants of team/group relations. They suggest that changes in domains are followed by dramatic changes in the goals, values and practices of

business organisations. To overcome this, they suggest there should be a shift to team working (systemic collaboration between clinicians and managers), which will increase the capability for innovation, while highlighting the importance of intangibles like knowledge, intellectual resources and intellectual capabilities, such as social and emotional capabilities (Tate, 2013). While Hyde, McBride, Young and Walshe (2005) suggest that through the redrawing of boundaries between these existing professional groups, new job roles can be established, although many stakeholders are still to be convinced about the need for change (Halliwell et al., 2000; Read et al., 2002) as seen in Hyde, McBride, Young and Walshe (2005). Assor and Oplatka (2003) present the conception of principals' growth based on four psychological perspectives: humanistic fulfilment/actualisation in terms of fulfilling basic needs and actualising interests and talents; psycho-dynamic in terms of learning to cope with and moderate extreme anxiety; moral/identity development in terms of forming reflection-based individualised moral and educational vision, and adaptive cognitive development in terms of constructing adaption-promoting knowledge and skills, which may be used to aid coping with the narrowing of the clinician – manager role within the primary healthcare sector.

2.3.4 Psychology

According to Gross (2010), psychology relates to the scientific study of the mind, in terms of behaviour and experience, derived from introspection, structuralism, behaviourism, and cognition. Without trying to answer the age old question of 'Nature' vs. 'Nurture' it can be noted that many psychologists agree that environmental influences are crucial for determining how capacities develop.

Levels of emotion in terms of 'anger' and 'joy', as introduced by Hartel and Page (2009) can be measured by the variable, 'affect intensity', used as a moderator of discrete emotions notably when comparing the crossover effects of psychological strain from one person to another. Following the implementation of the Health and Social Care Act 2012, Department of Health (2012a), the expected crossover between manager and clinician will be tested

further as the two functions, to some degree, will be carried out by the same person. Therefore the ‘affect intensity’ may also need to include an additional variable, for example ‘confliction’. The ability to cope with ‘affect intensity’ differs at various levels of management as described by Furnham, Crump and Chamorro-Premuzic (2007), following a study of managers, where they suggest that senior managers show high levels of Expressed Inclusion, in terms of a need to include others, but lowest Wanted Inclusion, in terms of a need to be included by others, while non-managers were found to be Dutiful and Diligent. They also noted that, in general terms, people in specialist technical roles tend be treated in a senior capacity due to their recognition for exceptional cognitive ability, but are often thought to be rather poor at management and leadership roles. Little research appears to exist where similar studies have taken place for general practitioners; however the idea that GPs are in specialist roles raises concern for their ability to manage, although due to their standing it would be expected that they too would show high levels of Expressed Inclusion; certainly an area for further research. Furnham, Crump and Chamorro-Premuzic (2007) conclude that self-confidence is argued to be a typical trait of senior management due to their comfortable and confident manner in decision making and assuming responsibility, which can also be argued as true for general practitioners.

Assuming general practitioners have a measure of self-confidence, Lau and Shaffer (1999) propose four personality traits: ‘self-monitoring’, ‘self-esteem’, ‘optimism’ and ‘Machiavellianism’ as key to career success. They suggest that career success helps individuals to fulfil their need for achievement and power, which can be related back to Borgatti and Halgin (2011) discussion around ‘choice; and ‘success’, as seen in figure 4 below – GP facet relationships.

However, ‘self-monitoring’ according to Lau and Shaffer (1999) is the ability and willingness to modify self-presentation and one’s sensitivity to expressive behaviours of others. It could be argued that general practitioners address these situations on a daily basis through the myriad of patient encounters. GPs could be argued as being high self-monitors due to their familiarity to the

situation, and their role expectations, in different environments. Kilduff and Day (1994) as seen in Lau and Shaffer (1999) goes on to suggest that low self-monitors insist on being themselves despite social expectations, which conversely suggests that high self-monitors are influenced by society.

In relation to high self-monitors, Lau and Shaffer (1999) as derived from (Brockner, 1988; Turban and Dougherty, 1994) continue to suggest that ‘self-esteem’ refers to how favourably individuals evaluate themselves. They note that high self-esteem individuals perceive themselves more positively and believe they are more capable and competent to cope with different situations and tasks, something that GPs are conditioned to be, following the intense training they undergo. These success experiences are attributed to a strong expectancy of further success, although in terms of GPs it could be argued that this attribute is limited to clinical expertise only.

Having a high sense of ‘optimism’ is seen as a reverse measure of pessimism which, in turn, can be described as a principal factor of negative affectivity (Lau and Shaffer, 1999). Levin and Stokes (1989); Turban and Dougherty (1994); Watson and Clark (1984) as seen in Lau and Shaffer (1999) continue to suggest that it is a relatively stable dimension of individual differences characterised by a tendency to experience positive emotional states, although Hochwarter et al. (1996) as seen in Lau and Shaffer (1999) showed that optimism is correlated to job satisfaction and job performance.

Machiavellianism is suggested by Lau and Shaffer (1999) to be a sort of manipulative strategy of social conduct that involves manipulating others for personal performance and success, which is often against other people's self-interest. Grams and Rogers (1990) as seen in Lau and Shaffer (1999) found that people who were high in Machiavellianism used indirect, non-rational tactics like deceit, but also appealed to emotions to try to plant their ideas to influence their colleagues. Machiavellianism is typically seen in sales and ‘just-in-time’ manufacturing, yet less so in the caring professions such as healthcare and third sector (Gable and Dangello, 1994; Wilson et al., 1996).

The role a person adopts relating to their career development, according to Bell and Staw (1989) as seen in Lau and Shaffer (1999) can be seen as sculpture or sculptor, which may be further described as the congruence approach. This is further discussed by Holland (1973) as seen in Lau and Shaffer (1999) who suggests that both vocational satisfaction and achievement, which can be related back to Borgatti and Halgin (2011) discussion around ‘choice; and ‘success’; relates to the fit between personality traits and environmental motives, as represented in figure 4 below. It is also argued by Holland (1973) as seen in Lau and Shaffer (1999) that the need for congruence appears to be self-evident, following the correlation between career success and the fit in values, personality, family background, needs, and ability. However they further suggest that even in incongruent situations, personality traits have effects on career success due to the ability where people actively learn and modify their behaviour or personality.

Intangible assets such as innovativeness, cognitive intelligence, emotional intelligence and social capital, highlighted by Goyal and Akhilesh (2007) are relative in terms of both individual and team working. As GPs, following the implementation of the Health and Social Care Act 2012, are now required to work both individually (as a GP) and as part of a team (member of clinical commissioning group), these abilities become very important. The term ‘general ability’, as described by Goyal and Akhilesh (2007), can be given to the collection of three of the underpinning abilities, ‘cognitive intelligence’, ‘emotional intelligence’ and ‘social capital’, which in turn cover a wide range of group behaviours. However as Goyal and Akhilesh (2007) continue to describe, that through the interplay between these three abilities, the group and individual can derive innovation.

Given the new position GPs find themselves in, following the implementation of the Health and Social Care Act 2012, they may experience anxiety as they realise the change process required. Baruch and Lambert (2007) present a framework for developing change management theory, based on its potential for prevention, recognition and treatment. They suggest that when encountering crisis, confusion, and difficulties, both individuals and

organisations can suffer from anxiety-related problems, and that prevention is only possible if methods of recognition have been identified through ‘threat’ training. As many GPs see themselves as clinicians first, it is unlikely that many GPs have undergone such training, leaving many primary care organisations vulnerable.

2.3.5 Reputation

Key stakeholders’ perceptions of an organisation are crucial to its reputation, as seen through their eyes and expressed through how their encounters meet their expectations which, of course, could be a different perception to the one the organisation believes they hold. These views will also influence a stakeholder’s expectation of how an organisation will act in a given situation, as described by Dolphin (2004). However, Davies et al. (2003) suggests that there are two main stakeholders of the reputation paradigm; employees and customers. In relation to these two stakeholders, they suggest the use of the term ‘identity’ which refers to tangible imagery such as logos, design cues, colour etc, and is taken to mean the internal view of the employees with the use of the term ‘image’ referring to the external view of customers (patients). They suggest the combination of ‘image’ and ‘identity’ collectively refers to ‘reputation’. However, a third perspective, ‘desired image’ refers to the view that the organisation itself aims to promote. The relationships between these three perspectives can be seen in figure 2 below.

Figure 2 – Reputation

(Source: Davies et al. (2003) adapted from Davies and Miles (1998))

Davies et al. (2003) continues that if image and identity are both embedded in the culture of the organisation, therefore image and identity are linked in causality, and as a result, the external image can be managed by managing the internal identity: the staff.

It can be argued that staff have a major influence upon organisational reputation, where Dowling (1993) as seen in Davies (2003) suggests CEOs for example, being responsible for the organisational mission and vision, can be seen to ‘give’ a part of their ‘style’ to that organisation. The image of Virgin is often associated with Richard Branson, and although Bill Gates is no longer the head of Microsoft, he continues to be closely associated.

Within the primary healthcare sector, it can be argued that the GPs are associated with the image of the practice. A traditional view and one the NHS has promoted in the past is that of doctor – patient relationship. Those practices who command a good doctor – patient relationship tend to also retain good employees; employees like to be seen to belong to reputable organisations (Davies et al., 2003).

With regard to the patient's whole experience of the NHS, it is determined by the umbrella branding of the NHS. All care sectors are obliged to use the NHS logo and its name as seen in figure 3.

Figure 3 – NHS Logo

Umbrella branding plays a significant role across the NHS corporate level as the company name *is* the brand name, and can be seen across all care sectors. Berry et al. (1988) as seen in Caruana (1997) suggest this type of branding is particularly important for the service sector.

Among academics, there are two schools of thought relating to corporate image, that of reputation synonymous with corporate image (analogous) and that of reputation different to corporate image (differentiated) as explained by Gotsi and Wilson (2001). They have concluded that there is a greater support for the differentiated school of thought showing that the concepts of corporate reputation are interrelated with that of corporate image, due to the everyday images that people form of the organisation, based on the organisations behaviour, communication and symbolism.

It is this symbolism derived from the desired Image, Image and Identity which underpins the organisational strategic approach, in that these facets directly influence the manner in which the organisational vision is obtained, and during the mission itself in achieving that vision, (Caruana 1997; Gotsi and Wilson 2001; van Riel 1997). In addition, Brunton and Matheny (2009) suggest it can be seen that radical change in healthcare delivery by GPs is possible through modernising tools and techniques, which is supported by Willcocks (2008) who suggests branding takes a central role alongside clinical leadership, but must ensure an ethical approach at all times.

2.4 Background Digest

In relation to the *'background to the healthcare sector'* in terms of public sector; health and social care act, including CCG's; primary care management; and patients, a number of issues facing primary care leaders can be obtained as seen in table 2 below; however one clear observation can be made, that GPs no longer work in isolation, and their management and leadership capabilities are crucial to meeting the objectives of the NHS Outcomes Framework (NHS Confederation 2011).

The role of a GP according to the battle of ideas (http://www.battleofideas.org.uk/index.php/2011/session_detail/5711) further describes how this has changed and what this means for the future of primary care in terms of GP skills, not only looking after patients health when they need it, but by the additional need to monitor patient lifestyles in order to prevent possible future illnesses, done so through innovative approaches to healthcare service delivery.

Table 2 – Background to the Healthcare Sector

Facet	*Issue*
Public Sector	Understanding stakeholder management for public sector leaders.
Health & Social Care Act, inc CCG's	The handling of political meddling relating to the privatisation of many NHS services.
Primary Care Management	Managing conflicts of interest – primary care leaders.
	The merging of health with social care.
Patient	Understanding the move from 'offering' to 'demanding' healthcare – Patient satisfaction.

In relation to the *'background to GP personal qualities'* in terms of social anthropology, education, relationships, psychology and reputation, a number

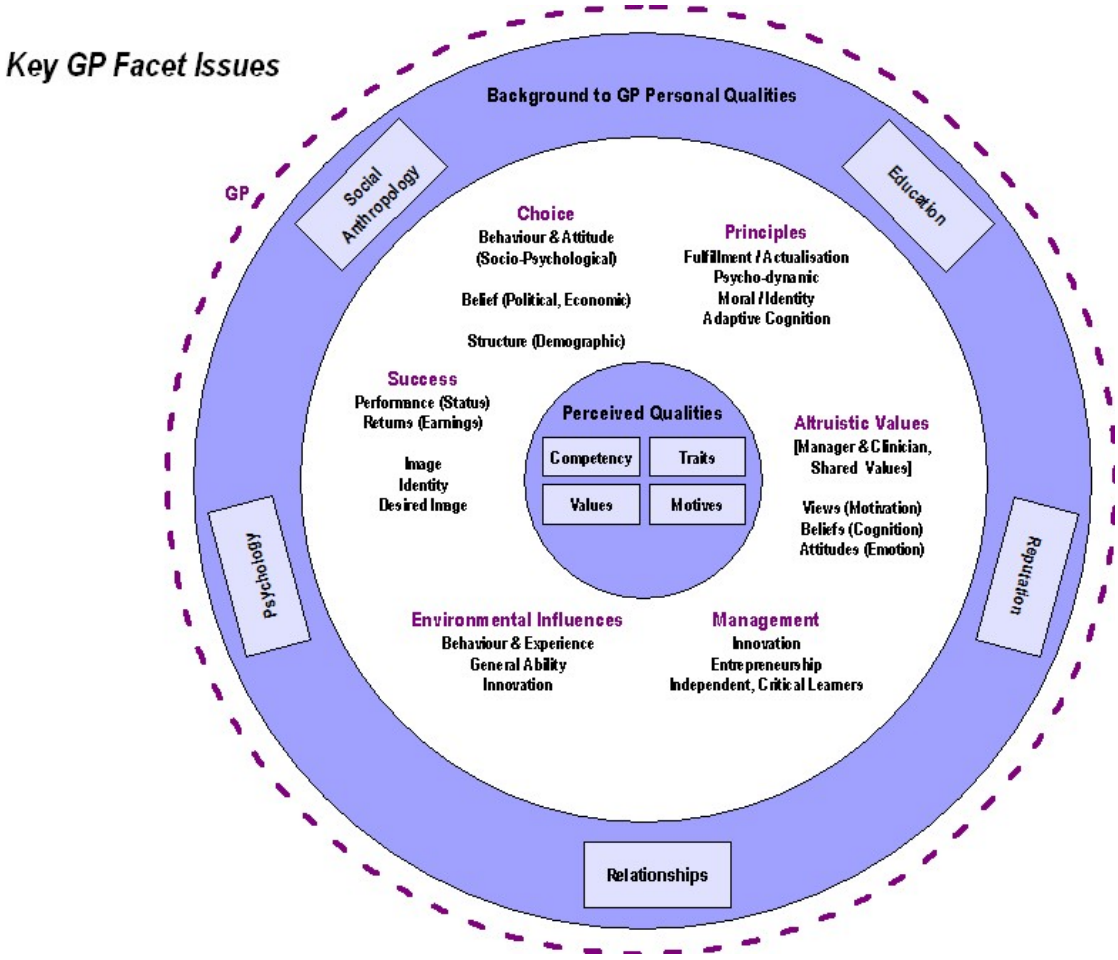
of observations have been made as summarised in table 3 below which may be used to underpin development of a GP qualities framework. In order for future GPs to meet the needs of the new NHS it could be argued that particular background influences can be seen to support a number of desired qualities.

Table 3 – Background to GP Personal Qualities

Facet	*Issue*
Social Anthropology	For the profession to retain its appeal, 'choice' and 'success' outcomes need to be retained.
Education	The development of independent, critical and continuous learners, spanning healthcare professions is vitally important in ensuring future GPs are able to adapt to the changing landscape of the NHS.
Relationships	Resolution of the love-hate relationship between clinicians and managers (clinical and management) is required, to the extent where the two roles become complimentary.
Psychology	An understanding of GP 'behaviour' and 'experience' is required to support the development of their 'general ability' in order to 'innovate'.
Reputation	Image, Identity and Desired Image measured through doctor - patient relationships may well continue to be key measures of NHS success.

The above observations are described further in figure 4 below, which shows some of the relationships between the 'background to GP personal qualities' and the 'perceived qualities', discussed in chapter three below.

Figure 4 – GP Facet Relationships



(Researchers own model)

By focussing in on the literature discussed in the 'background to GP personal qualities', represented by the outer circle of figure 4, it represents a number of key issues faced by GPs, in terms of 'choice' and 'success' (Borgatti and Halgin, 2011), 'principles', (Assor and Oplatka, 2003), 'altruistic values' (Merali, 2003), 'management' (Adcroft, Willis and Dhaliwal, 2004), and 'environmental influences' (Gross, 2010). These facets derived from the literature review are used to develop the perceived qualities, represented by the inner circle, that underpin the direction of study which will be discussed further in chapter 3.

In terms of participating in cultural phenomena, it can be seen from an 'emic' perspective: GP behaviour and/or beliefs, both consciously and unconsciously, are influenced by their culture, predominantly in terms of their

standing within the community, based upon their choice, success, principles and values. However, in terms of being an observer of cultural phenomena, from an ‘etic’ perspective, observers may well perceive their behaviour and/or beliefs as a result of their ability. In terms of GPs as commissioners, this ability must relate to both clinical and managerial/leadership skills when meeting the demands of the NHS Outcomes Framework, as described by NHS Confederation (2011). In terms of GPs as providers, this ability must relate to autonomy as business leaders and value for money from a patient perspective while meeting their healthcare needs.

2.5 Summary

This chapter has examined the background to the healthcare sector, which introduced a number of key facets: Public Sector, Health & Social Care Act 2012 including CCGs, Primary Care Management, and Patients. These facets were used to set the context for how GPs must now focus their attention in relation to their skills in organisational development and organisational fit to the primary healthcare sector, from a general practice perspective. In addition this chapter has also looked at the background GP personal qualities; Social Anthropology, Education, Relationships, Psychology, and Reputation in relation to GP aspirations. Through this theoretical lens, these underpinning facets build an understanding of the key relationships, in the form of ‘perceived qualities’, required to support general practitioners, as providers, in their new role in the delivery of primary healthcare, as a result of the Health and Social Care Act 2012. The next chapter looks at these ‘perceived qualities’ in terms of GPs acting as clinicians, commissioners and providers.

3 Review: Issues Related to the Perceived Qualities

3.1 Introduction

This chapter explores the crux of the problem – perceived qualities of a GP, specifically obtaining an understanding of what issues need to be addressed, in terms of the available qualities held by GPs in order to meet the needs of the Health and Social Care Act 2012, and in relation to GPs as business owners (providers) as well as commissioners, over and above those qualities required as clinicians.

It first considers GP 'competencies' from a management/leadership perspective and how these may be developed, and/or transferred from their existing skill set as clinical leaders. Followed by a review of their 'traits' and how these may influence change in healthcare delivery, through identity, intelligence, and transparency. Then explores underlying 'values' and what may have influenced them, in terms of shared values, moral judgement and competing values, finishing with 'motives' and how status and earnings can be a further influencing/motivational factor, underpinned by personal goals, and identity. These competencies draw from the key GP facets identified in figure 4 above.

3.2 Reviewing the Issues

3.2.1 Competencies

Competence is the quality of being adequately or well qualified physically and/or intellectually, as defined by WordNet (2013a). Understanding the context of how this relates to a GP in terms of both doctor-patient relationships, and employer-employee relationships is considered.

Patients believe general practitioners (GPs) should have particular qualities and behaviours during a medical encounter (Gruber and Frugone 2011), in particular, those that reveal the most value are those that demonstrate an understanding of the underlying issues during personal encounters. This

seems important when understanding patient's needs and desires in order to help underpin any transferrable qualities required as a GP commissioner or provider.

In the case of a service encounter, patients believe that GPs need to show competence, friendliness and empathy in order to gain their trust (Garry, 2007; Michel, 2001) as seen in (Gruber and Frugone, 2011). GPs should also listen carefully and do the appropriate tests and checks in order to find the underlying cause of the problem (Reynolds and Gutman, 1988) as seen in (Gruber and Frugone, 2011). 'Health' is deemed a significant value sought by patients which is considered to be the first step to moving on with their everyday lives while they also look for other values such as belongingness, well-being, accomplishment, and self-realisation as seen in Gruber and Frugone (2011). They also suggest that patients would like to gain knowledge about their conditions in order to manage them in the future and to have some sense of control over the decision of any treatment. They continue to suggest that patients also want a more active role in their healthcare encounter, which calls for a more shared approach between them and their GPs. Following the Health and Social Care Act 2012, GPs will be best placed to ensure patient values are met, although the issue of funding may now be introduced into the equation which will also need to be accounted for.

In order for GPs to make best use of these qualities, they must be transposed into an appropriate management model where Boyatzis (1982) discusses the cross-over between scientific management to humanistic management, which draws on skill, dexterity and knowledge to form a management model, while Wickramasinghe and De Zoyza (2009) investigate whether there is a set of management competencies that should be possessed by managers irrespective of their areas of functional specialisation. Although their study of 31 individual competencies are analysed and confined to a fully integrated telecommunication service provider, many of the methods can be used in the primary healthcare sector. The findings reveal broad level competencies that are important for managers working across seven functional areas: Finance, IT, Marketing, HR and Administration, Legal, Planning and Corporate Strategy

and Operations (Agut et al., 2003; Hackett, 2001; Tubs and Schulz, 2006; Yang et al., 2006) as seen in Wickramasinghe and De Zoyza (2009). It is worth noting that their findings (telecommunication staff) suggest the importance of competencies covering value and skill clusters outweighed the knowledge cluster across all functional areas, although it can be argued that knowledge underpins skill. However, due to the nature of primary healthcare it may be further argued that this may not always be the case; this area of study would certainly benefit from further research.

In terms of director level competencies, Coulson-Thomas (2009) suggests it is possible to identify, categorise and prioritise the competencies that directors require to be more effective in their roles. In the context of director level (partner level) competencies, there are a number of key competencies that relate to the distinction between management and direction (Coulson-Thomas, 2007a) as seen in Coulson-Thomas (2009), which should be considered in conjunction with the responsibilities of directors as set out in the Companies Act 2006. The guide, ‘Good Practice for Directors – Standards for the Board’ (IoD, 2006) as seen in Coulson-Thomas (2009) shows a number of attributes required by a competent manager/director. These have been categorised into six headings: achievement of results, analysis/information management, communication, decision making, interaction with others and strategic perception. GPs already utilise these attributes as clinical leaders, however it is the context in which they are now required to carry them out that requires a new focus, that of financial controller.

Carmeli and Tishler (2006) examined the effect of nine managerial skills of the senior management team including: administrative ability, persuasiveness, fluency in speaking, diplomacy and tact, knowledge about group tasks, social skills, conceptual skills, creativity, and cleverness, and how this effects overall organisational performance. Although it was seen that the sum of these skills did affect organisational performance, it was those skills required in the management of people that were found to have more importance over intellectual abilities. In comparison, GPs are thought to be naturally less employee focused due to their private consultations with patients taking up the

majority of their time, leaving little left over for people (employee) skills. GPs are required to be mindful of this while dealing with employees as key stakeholders, and should look to develop this competence further, such as Weick and Roberts (1993) work around ‘collective mind’ which is conceptualised as a pattern of heedful interrelations of actions in a social system, in terms of contributions, representation and subordination. As mindful comprehension increases, organisational errors decrease.

Looking at public/non-profit and for-profit organisational leaders may help identify some of the differences that exist in leadership style, behaviours, and competencies that drive performance in different sectors, and which may well help GPs make their transition to business leaders. Although Thach and Thompson (2007) conclude little difference across these sectors, it can be seen that sales related competencies show the greatest difference between public and private sectors. GPs being members of the public sector may well benefit from the obtaining of such skills seen in the private sector, although still a controversial subject, given healthcare is given free at the point of delivery (Department of Health, 2003; McDonald, Harrison and Checkland, 2008).

An effectiveness of a leadership development program was evaluated by Cherniss, Grimm and Liautaud (2010) based on the International Organisation for Standardisation (ISO) principles, with the intention to help participants develop their social and emotional competence. Based upon the Emotional Competence Inventory (ECI) measure, results showed significant improvement over expected. In contrast to the traditional method of setting a single goal, and targeting a behavioural or skill change in a short period of time, Leonard (2008) examined the efficacy of setting multiple goals targeting complex competencies across a number of years. Benefits were seen where participants made continued effort in their development of these goals.

It is suggested that competency development should contain an overall narrative definition, plus 3 to 6 explicit ways to exhibit the competency within the organisation (Spencer and Spencer, 1993) as seen in Thach and

Thompson (2007). In order to be useful, competency models should provide specific behaviours the individual needs to emulate, as well as offering an explanation of the expected business outcomes and benefits produced by that competency. It could also be argued that organisations need to know what competencies to target before they can develop, implement, and evaluate appropriate training programs designed to augment those competencies. In agreement, McLagan, (1983) as seen in Thach and Thompson (2007) suggests an effective development and implementation of leadership competencies, including an accountability system, is deemed critical for success.

3.2.2 Traits

Trait is a distinguishing feature of one's personal nature, as defined by WordNet (2013b). Understanding the context of how this relates to a GP in terms of both doctor-patient relationships, and employer-employee relationships is considered.

During the development of the Health and Social Care Act 2012, one key assumption, that has gone largely unchallenged, is that GPs are best placed to know and represent the needs of their patients, as described by Talbot (2012). He continues to suggest that this assumption underpins the whole idea of GP led commissioning, and raises concerns that systems of control, regulations, inspections and transparency are in danger of being lost. Without such governance and accountability, GPs' character is likely to be put into question. This may be achieved if GPs offer transparency relating to all decision making, both in terms of patient healthcare, and their organisational development.

This assumption is closely related to GP identity, where Cascon-Pereira and Hallier (2011) have taken this idea further by looking at the role of emotion when individuals construct and enact professional identity. It was found that taking a social identity approach proved useful especially when generating insights within the work setting. Awareness of identity issues requiring

attention became more apparent when considered through emotions, which lends itself to GPs when understanding the complex role relating to different sides of doctor manager identities.

Stein, Papdogiannins, Yip and Sitarenios (2009) identify that executive groups scored highly with emotional intelligence in relation to organisational outcomes such as growth management, employee management and retention, and net profit. These executives possessed high levels of self-regard, reality testing, empathy and problem solving. It could be argued that GPs also hold these qualities; however the subtle difference is in the key stakeholder; executives hold the organisation in the highest regard, whereas GPs tend to hold the patients in the highest regard. Emotional intelligence in relation to job satisfaction, according to Chiva and Alegre (2008) is also influenced by organisational learning capability. However, in terms of innovativeness required as a result of the Health and Social Care Act 2012, cognitive intelligence, emotional intelligence and social capital lead to the higher functioning of a team/groups ‘general ability’ to achieve, as suggested by Goyal and Akhilesh (2007).

As leaders of reconfiguration of the NHS, GPs must also determine the different capabilities of multilevel organisations. Hawass (2010) argues that an inter-firm collaboration offers significant benefits, while group-level learning helps recombine knowledge streams. This lends itself to the suggestion of federation or alliances across primary care settings, although GPs must distinguish themselves between patient-led care and organisation-led care. Emphasis should also be made to the role of organisation-level learning in the context of reconfiguration capability. This could prove useful for clinical commissioning groups as they evolve from pre-existing organisations, under the influence of GPs. Meanwhile during this period of change GP leaders must monitor the effect of organisational culture in terms of the relationship between leadership and knowledge management through both transformational and transactional leadership, (Nguyen and Mohamed, 2011).

3.2.3 Values

Values are beliefs of a person or social group in which they have an emotional investment, as defined by WordNet (2013c). Understanding the context of how this relates to a GP in terms of both doctor-patient relationships, and employer-employee relationships is considered.

Existing and emerging primary healthcare leaders and managers must recognise the importance of values in terms of how they relate to the delivery of primary healthcare and how it relates to those emerging primary healthcare organisations from both an individual and organisational perspective as described by Hobkirk and Deuchar (2011), and who continue to suggest that these leaders and managers should pay particular attention to how values effect patient care during current financial austerity, rate of change, and quality improvement. Logan (2009) describes shared values at stage 5, as being the pinnacle of all tribal stages, where the whole tribe have come together based upon their values and with a shared aim to achieve their ultimate cause. These shared values can empower relationships between providers and commissioners and between related professions, leading to an advancement of priorities beyond politics and morals towards shared goals and strategies, (Hobkirk and Deuchar, 2011).

Hume (1978) as seen in Armour (2003, p. 37) draws on his work around the fact/value dichotomy, by insisting that we have what most people would call knowledge of values:

> *“Let a man’s insensibility be ever so slight, he must often be touched with the images of right and wrong”*.

And he adds that the ‘moral eccentric’ will probably *“at last come over to the side of common sense and reason”*, suggesting that a clear understanding of common sense and reason underpins moral judgements. However, such judgements that develop into decisions forming part of an organisational strategy within the public sector should include values, ethics and morals, as

described by Sirsly (2009), although Braybrooke and Lindblom (1963) warn that ‘ethical theory cannot make bad actions impossible’, and that multiple moral judgments can be contradictory, so any strategic decision outcomes must therefore be achieved upon the concept of justice.

Community acceptance of the concept of justice enables organisations to come together as a result of their shared values, across the primary care setting, and will come to symbolise their community’s aspirations and sense of identity (Selznick, 1957). This sense of identity also becomes desirable in terms of social values; however this will require responsible leaders to maintain it. In terms of the primary care setting, this role fits with the role currently carried out by GPs, although such values require protection from compromise as described by Drucker (1954) insomuch as responsible leaders must avoid opportunism and utopianism.

Leaders draw on their professional and social skills and knowledge when making judgements as described by Barnard (1950) seen in Isomura (2010), although moral judgements may be made without adequate skills and knowledge. These moral judgements are therefore drawn from those shared values across the social group; however judgements made in times of need should be seen as separate to the role of responsibility. These moral values are derived from wider rudiments chosen based upon articulated principles (Nardo and Francis, 2012). Furthermore, caution is required where charismatic leaders exercise their own beliefs, behaviour and values over those shared values across the social group for purposes of power, (Aaltio-Marjosola and Takala, 2000; House, 1997; House, Spangler and Woycke, 1991).

Following the Health and Social Care Act 2012, primary care leaders need to demonstrate measurable change both organisationally and culturally. Marshall et al. (2003) identify two distinct yet polarised styles of management with competing values, one adopting a hierarchical directive style which challenges the values of clinicians while following a political agenda, and the other adopting a clan-type facilitative style which draws on shared values from

within; these two approaches can lead to strain between the different functions of management.

The competing values framework, as seen in figure 5 below, describes four basic organisational cultural types. Organisations may possess more than one of these types, but one of them is usually dominant.

Figure 5 – Competing Values Framework

Source: Marshall et al. (2003) adapted from Cameron and Freeman (1991)

The researcher argues that primary care organisations traditionally adopt a clan culture with an ‘internal focus’ and a ‘relationship based process’, due to the perception that those organisations deliver patient care, based upon proven clinical methods and with little fear of competition. However, facing the new landscape of UK healthcare, the move towards a more developmental culture, showing an external focus may prove useful, especially when developing alliances across localities, which fits with stage 5 of tribal membership when there is a coming together based upon their values as seen in Logan (2009).

3.2.4 Motives

Motives are psychological features that arouse an organism to action toward a desired goal; that which gives purpose and direction to behaviour, as defined by WordNet (2013d). Understanding the context of how this relates to a GP in terms of both doctor-patient relationships, and employer-employee relationships is considered.

Gross (2010, p. 473) suggests that those who advocate the *empathy-altruism hypothesis* (EAH) agree that the majority of what we do (including what we do for others) is egoistic. He continues to describe that in certain circumstances, we have the capability to undertake different qualitative forms of motivation, with the intention to *benefit others*. Furthermore, Locke (1997) suggests motivation is driven by goals, human desire and supposed personal needs in relation to their environment, (Hackman and Oldham, 1980; Herzberg, 1968). Incentives to work result from both intrinsic and extrinsic rewards, assuming personal motivation, and satisfaction to work comes from the nature of the job performed.

Identity, as a feature of motivation, is seen as a growing facet of social and organisational identification (Beck et al., 2000), seen in healthcare organisational roles such as doctoring, nursing and administration where employee attitudes, values and behaviours are distinctly noted (Degeling et al., 1998). Identity is also associated with differing levels of stress (Winefield, 2000), although higher status staff appear to experience fewer negative threats of change than lower status staff (Kanter et al., 1992). The current changes to the primary healthcare landscape may be perceived as a threat to the GP professional group and their identity (Covin and Kilmann, 1990; Watson et al., 2005), so leaders need to maintain the group status and the required adjustments of their employees. Those belonging to higher status groups tend to adjust to change better than those belonging to lower status groups. It is commonly accepted that clinicians belong to the higher status group and administrative staff belong to the lower status group. However, Hoedemaekers (2009) suggests that individuals with positive self-identity can

take on the status that fascinates them, and therefore invest effort in obtaining it, and who further argues that roles can engage the subject through the linking of images of organisational success to their career trajectory, although this may fail to deliver and cause a displacement of the subject's desire.

Hoedemaekers (2009) defines leadership as *'the ability someone has to make others desire what they desire',* where through their actions, those around them 'instinctively' wish for the same goals, while Pink (2008) explores this idea further 'through the lens of mimetic desire' suggesting that individuals are not unique but copy the behaviour of others in order to learn and progress, seen by effective leaders who are able to guide mimetic desire into shared goals, values and outcomes (Girard, 1961) as seen in (Pink, 2008). Girard continues with the suggestion that individuals use mimetic desire for more than skill acquisition and behaviour but also desire, which is seen more clearly in young children who desire what their parents/guardians/and immediate circle members' desire. Primary care leaders may well be facing opportunities during the current changes as a result of the Health and Social care Act 2012 to lead by example that professionalism can coexist with patient participation leading to cost effectiveness, although they must remain vigilant to the possibility that this may cause internal conflict and rivalry within the community. The understanding and awareness of mimetic desire psychology may need to be developed while influencing individuals (Gross, 2010; Pink, 2008). Primary healthcare leader's behaviour while acting as role models would benefit by using mimetic desire as an underpinning theory to reassert the term 'organisational leadership' as both members of clinical commissioning groups, and leaders of primary health care organisations.

Behavioural approaches to leadership remain a significant element in leadership literature (Jackson et al., 2012) where leader reward behaviours are central to models such as the path-goal model and transactional leadership (Bass, 1985; House, 1996) as seen in Jackson et al. (2012). This follows meta-analytic evidence that behaviours following leader reward determine subordinate attitudes and performance (Judge and Piccolo, 2004; Lowe et al., 1996; Podsakoff et al., 2006) as seen in Jackson et al. (2012).

Furthermore, Armstrong, Brown and Reilly (2011) suggest that evidence-based management provides a systematic basis for evaluating reward, although '*thinking about pay ought to be based on logic and evidence, not on belief or ideology'*, (Pfeffer, 1998, p. 196) and also must be seen to be fair in order for leader reward to obtain the desired effects from subordinates. When individuals believe that rewards are allocated fairly they are more likely to demonstrate increases in morale, and therefore more likely to reciprocate (Rosen et al., 2009; Shore et al., 2004; Tekleab et al., 2005). However, Sabetzadeh and Tsui (2011) remind us that behaviour can also be enforced through sanctions and that apparently good behaviour may be stimulated by the need to avoid ridicule within their social circle (Becker, 1974).

Ones 'desire to be empowered' as suggested by Honegger and Appelbaum (1998) refers to the extent to which an individual wants to be empowered, although measured by the consequences of increase in workload and responsibility this may be deemed negative (Spector, 1988). However Von Dran (1996) suggests that individuals predominantly hope for greater self-determination and crave to have influence and control over their environment. Therefore employees who desire to be empowered are less likely to be put off by problems and are more likely to overcome them in order to become empowered (Honegger and Appelbaum, 1998). However, Greasley et al. (2004) suggest senior individuals may resist empowerment of juniors, which could be seen as a surrendering of their power, while Denham et al. (1997) continue further that any reduction of power may be treated as a threat, even if empowerment of juniors is an organisational policy. To counter this Sabetzadeh and Tsui (2011) note that reputation is a valuable means of advancement, and subject to increases in remuneration, may even be identified as a personal goal.

Individuals who primarily respond to external perceptions of reward tend to be drawn to materialistic forms of work based reward, while those who respond intrinsically tend to relate well-being based upon motive congruence with their own interests, satisfaction, pleasure and purpose (Ryan and Deci, 2000). However London and Higgot (1997) suggest that quality management may

suffer as a result of reward and recognition systems due to their method of implementation, and suggest that continuous improvement established through Total Quality Management (TQM) methods provides a clear and visible message to the whole workforce of the organisational values and employee commitment. Although motivation is still recognised as an intrinsic element of human nature, where recognition for a job well done is sought (Scholtes, 1995; Sweatman, 1996). The use of reward-mix has been suggested by Chapman and Kelliher (2011) in response to the existing narrow definition of reward being based upon pay, in the form of wages, salaries, incentives and bonuses. Reward-mix introduces social motives (Sabetzadeh and Tsui, 2011) which relates to human nature and social roles, but does require compliance with social systems. Some motives are revamped as part of social based knowledge systems where intrinsic rewards can be shared through altruistic participation; something GPs are known to aspire to.

This means that general practice leaders must gain an understanding of their own personal qualities in order to inculcate shared goals, values, attitude, behaviour and self-identity towards their workforce through influence and control, mimetic desire, reward and empowerment.

3.3 Issues Digest

In relation to the *'perceived qualities'* outlined above, a number of issues facing primary care leaders can be drawn as seen in table 4 below; however it can also be seen that there is potential for the experiences of GPs to be transferrable across both clinical and managerial domains.

Table 4 – Perceived Qualities

Facet	*Issue*
Competency	The ability to implement the cross-over of skills between clinical leadership and management leadership
	Obtaining a clear understanding of leadership responsibilities including both moral and legal
	Making conscious decisions to be employee focussed with the aim to develop organisations
	The need to be more aware of markets and marketing
	Openness to the development of multiple competencies over time rather than single competencies in a short period of time
Traits	Due to the complex position GPs find themselves, there is a greater need for transparency of both their clinical and organisational activities
	Development of both patient-led and organisational-led learning

Table 4 – Perceived Qualities, continued...

Values	Empower relationships between providers and commissioners, and between related professions
	Assert the concept of justice as a key driver of shared values
	Desist from choosing one's own values above those shared values held by the group
Motives	Awareness of both higher status and lower status individuals
	Through the use of mimetic desire, lead individuals towards a common set of goals, values and outcomes
	Coexistence of professionalism with patient participation leading to cost effectiveness
	Conscious evaluation of behaviours linked to reward
	Promote and develop the desire to be empowered

From an 'emic' perspective, in terms of participating in cultural phenomena, it can be seen that GPs as business leaders can have influence over individuals through their transferrable skills as clinician leaders, and by taking a moral and legal responsibility for change and openness to development, while from an 'etic' perspective, in terms of being an observer of cultural phenomena, GPs can learn from observation of how other individuals cope with cultural change.

3.4 Summary

It can be seen from the above issues related to the perceived qualities (Competency, Traits, Values, Motives) that the proposed qualities framework must enable GPs to provide patient healthcare while meeting the demands of commissioners, and do so in such a way that they themselves want to participate in the healthcare sector. Those leaders must be competent in a moral and legal manner, be employee focussed, understand markets, and be

open to personal development. They must have traits which show their transparency and eagerness to develop their organisation and themselves. They must embrace values which empower relationships across professions while desisting from choosing their own values over those of the organisation. Their motives must inspire others towards a common set of goals, while being conscious of their behaviours linked to reward.

A number of issues have been raised relating to both, the healthcare sector, and GP personal qualities, and in order to respond to those issues, GPs with these perceived qualities will be best placed to meet the needs of primary care from a provider perspective. In addition, as a result of this, those primary care organisations led by GP leaders is directly proportional to CCG's meeting their needs as commissioners.

The next chapter introduces a conceptual framework based upon the facets identified in the previous two chapters, and how they relate to each other in order to present an overview of the personal qualities required for general practitioners to deliver 21st century healthcare from a business perspective.

4 Conceptual Framework

4.1 Introduction

From the previous review chapters, the researcher identifies and discusses a number of facets relating to the perceived qualities required of modern general practitioners in order for them to lead the NHS, in terms of general practice, in the delivery of the NHS Operating Framework (Department of Health, 2011).

This chapter first introduces a conceptual framework to help understand those specific areas, defined as ‘NHS’ related and ‘GP’ related and their relationships with each other, in order to support the development of a GP qualities framework for use by both current and prospective GPs in their future career decisions, in relation to business management and leadership.

The following sections focus upon the qualities required for business management tasks only, as clinical qualities are outside of the scope of this research project.

It includes the development of a qualities framework to help understand what is required of modern GPs, from a general practice business management and leadership perspective, and which may also help future aspiring GPs with their learning plans, based around their chosen career paths, when training to become a GP.

4.2 GP Qualities Frameworks

4.2.1 Foundation

There are five domains pertaining to the Operating Framework for the NHS in England (Department of Health, 2011), as seen in table 5 below. These domains give focus to how the NHS plans to deliver patient care, as it is faced with an aging population.

Table 5 – Outcomes Framework – 5 Domains

1	Preventing people from dying prematurely
2	Enhancing quality of life for people with long-term conditions
3	Helping people to recover from episodes of ill health or following injury
4	Ensuring that people have a positive experience of care
5	Treating and caring for people in a safe environment and protecting them from harm

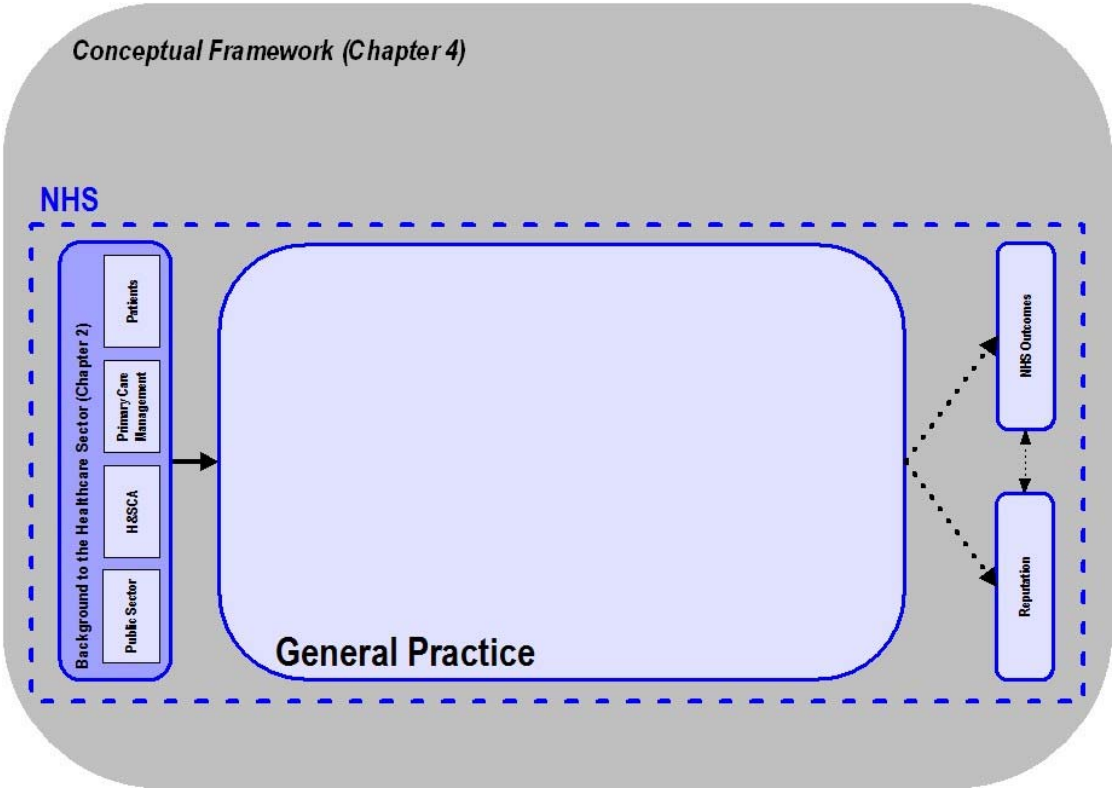
Following the recent reforms as a result of the Health and Social Care Act 2012 there have been considerable changes to the whole structure of the NHS. Key to these reforms is the abolishment of Primary Care Trusts (PCT) in favour of Clinical Commissioning Groups (CCG) (Wood and Ward, 2011), and public health moving under local government control (Ham, Dixon and Brooke, 2012). As a result of these changes, it is clear that government wish to move many healthcare services into the community (Bowerman, 2006; Kings Fund, 2013; Longlett, Kruse and Wesley, 2001) led by general practice.

CCG's are made up from member GP practices across localities which, in the main, mimic local government localities (Wood and Ward, 2011). This puts general practice at the heart of NHS service delivery and gives key responsibility to meeting the five domains of the NHS outcomes framework. In addition, clinical commissioning groups are taking control of the healthcare budget, and are responsible for the commissioning of services for their patients (Department of Health, 2012).

Maintaining core existing services from other care sectors, requires general practice, as members of clinical commissioning groups, to have both clinical and business management and leadership expertise, while the transferring of services into the community suggests general practice must also demonstrate business related innovation and creativity (Checkland, Harrison and Marshall, 2007). How general practice develops itself as a provider to help meet these needs is crucial to meeting the NHS outcomes framework. Any expertise, creativity and innovation demonstrated by general practice must draw on the

wider NHS structure in terms of the public sector, the Health and Social Care Act 2012, primary care management and the needs of the patients, as outlined in figure 6 below, if it is to achieve the desired outcomes while maintaining/improving overall NHS reputation.

Figure 6 – NHS Needs Assessment

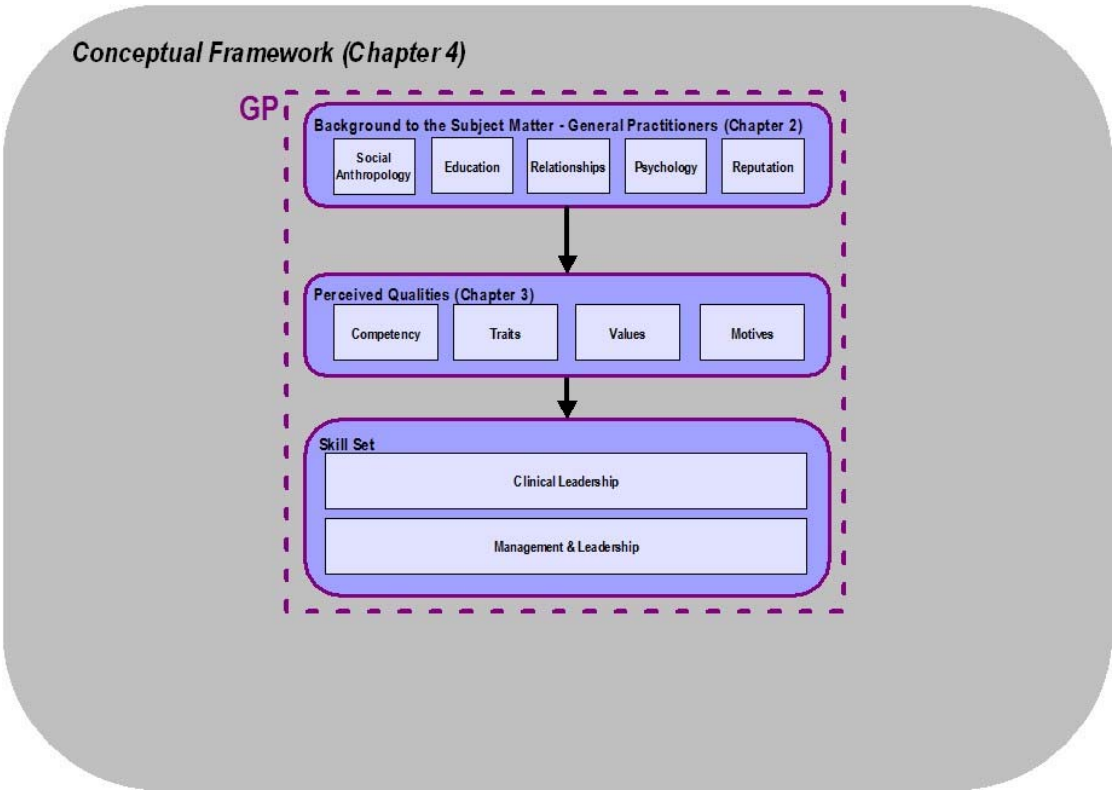


(Researchers own model)

It can be seen from the graphic in figure 6 that the wider healthcare sector represented as the 'background to the healthcare sector' feeds into 'General Practice', represented by the direction of the arrow in terms of activity flow, which functions as a portal to the patient population. The function of general practice is directly proportional to the NHS Outcomes and Reputation, represented by the dotted arrow in terms of activity flow, seen within the blue dotted line. Although patients may access healthcare across other care sectors, it is primary care, represented by 'General Practice' that must now manage access to those other healthcare organisations, and therefore act as the gatekeeper to the whole healthcare system.

The graphic in figure 6 shows four key areas of the NHS: Public Sector, Health and Social Care, Primary Care Management and Patients, where general practice must make sense of these influences when making both provider and commissioning decisions in order to maintain overall NHS reputation, and deliver on the 5 domains of the NHS outcomes framework. General practice must now look to itself, systemically, to ensure it is capable of meeting these expectations, which requires general practitioners (GPs), as key leaders of general practice and in collaboration with practice managers, to obtain appropriate expertise in addition to their clinical skills, relating to business management, creativity and innovation. These skills are required to ensure that general practice as an entity has the ability to participate in the wider delivery of healthcare. The graphic in figure 7 below demonstrates the 'leadership' role of GPs in relation to 'General Practice' as part of the wider NHS.

Figure 7 – GP Needs Assessment



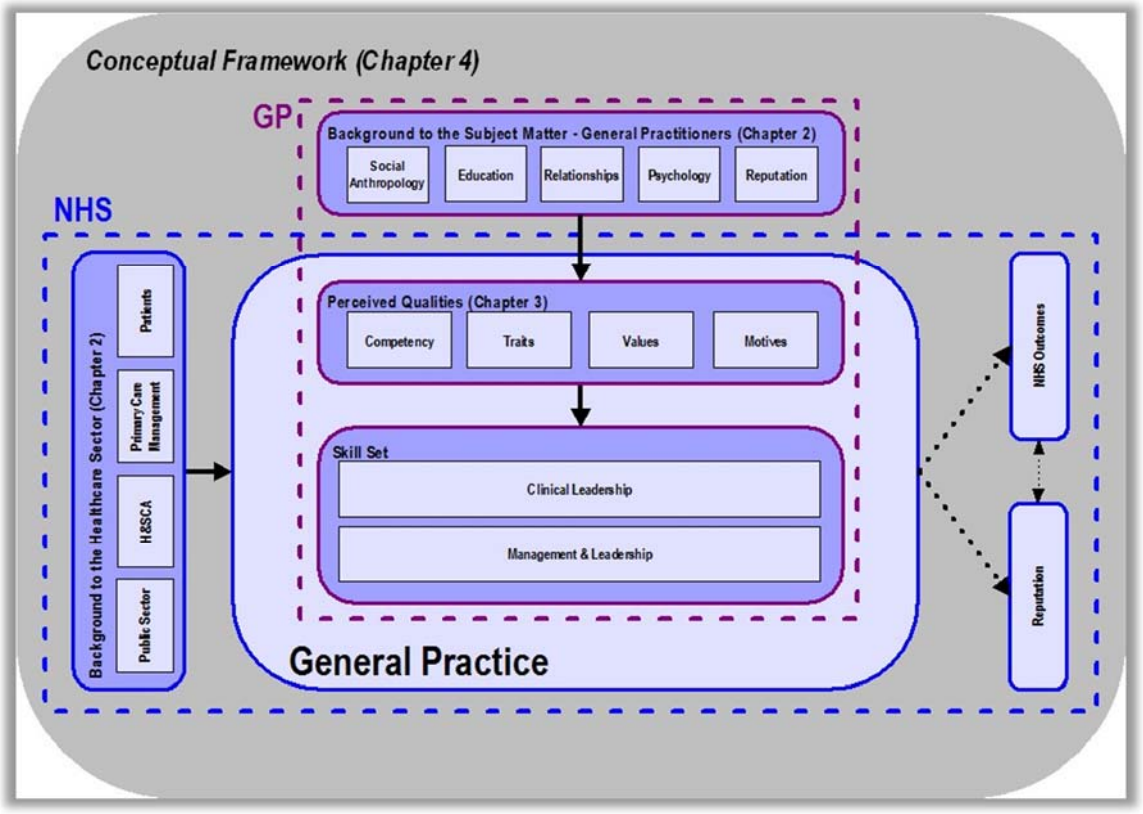
(Researchers own model)

It can be seen from figure 7 that modern GPs, seen within the purple dotted line, require skills in clinical leadership and management & leadership. Doctors who become GPs have a choice of becomming a locum GP, salaried GP or GP Partner. Locum and salaried GPs now have responsibility, as members of clinical commissioning groups (Wood and Ward, 2011) to have basic business management skills in order to participate in the decision making of healthcare service delivery, while GP Partners must have the same. plus more advanced skills, in line with their additional duty as business owners.

The graphic in figure 7 identifies a number of key facets: social anthropology, education, relationships, psychology and reputation which feed (represented by the direction of the arrow in terms of activity flow) four perceived qualities; competency, traits, values and motives, as discussed in chapter 3. It is from these four perceived qualities that the researcher will formulate a competency framework, from a business perspective, for use by emerging and existing general practitioners in their efforts to participate, and become effective leaders, as both providers and commissioners, in the commissioning cycle.

The framework in figure 8 demonstrates how the needs of the NHS, as seen in figure 6, comes together with the role of GPs, as seen in figure 7. It can be seen that ‘General Practice’ becomes the conduit to delivery of healthcare services outcomes through its leaders, GPs. In support of this, the GP skill set must draw on a key set of qualities; competency, traits, values and motives which are deemed to be largely influenced by their social anthropology, education, relationships, psychology and reputation.

Figure 8 – GP/NHS Needs Assessment Framework



(Researchers own model)

Therefore, as modern GPs require skills in both clinical and management areas (Clark and Armit, 2010), those underpinning qualities must (in varying degrees) include qualities relating to them both in order to meet the future needs of the NHS, as it emerges following the implementation of the Health and Social Care Act 2012.

Competency frameworks can be seen in the literature for a multitude of reasons; however little exists around the concept of GPs as business leaders (Clark and Armit, 2010), especially in relation to their new role as lead commissioners for the NHS. By taking a look at some existing frameworks the researcher plans to develop a framework which suits the unique situation general practice finds itself in.

4.2.2 Related Frameworks

Clark and Armit (2010) reiterate that there appears to be a limited number of competency frameworks covering GP leadership available, and note the increasing acknowledgement by the medical profession that doctors need to also be competent managers and leaders, and that management and leadership competency frameworks should be included within core training. This suggests the need for a qualities framework to support primary care leaders in their delivery of 21st Century healthcare.

The NHS Institute for Innovation and Improvement and The Academy of Medical Royal Colleges have recently developed an integrated medical management and leadership competency framework (seen in appendix four and five) which covers seven domains:

1. Demonstrating personal qualities
2. Working with others
3. Managing services
4. Improving services
5. Setting direction
6. Creating the vision
7. Delivering the strategy

It can be seen from the expanded view of the seven domains, as seen in appendix five, that each domain has four elements of demonstrable effectiveness. This framework is based upon the ‘distributed leadership’ model (Bolden, 2011; Clark and Armit, 2010; Cope, Kempster and Parry, 2011; Currie and Lockett, 2011; Edwards, 2011; Fitzsimons, James and Denyer, 2011; Kings Fund, 2011; Tate, 2013; Thorpe, Gold and Lawler, 2011) used for interdependent and complex tasks. Distributed leadership is the leadership approach in which collaborative working is undertaken between individuals. From the seven domains, five are identified as core domains, for the development of entry level and intermediate level leadership. Domains six and seven are aimed at advanced leaders in senior roles. For each element within

these domains, the framework is designed to be more progressive by following the four stages, seen below:

1. Own practice/immediate team
2. Whole service/across teams
3. Across services/wider organisation
4. Whole organisation/healthcare system

In addition, the competency framework is supported by six organisational toolkits: '*organisational development', 'leadership development', 'coaching', 'assessment', 'team development',* and *'360 degree feedback'*.

It is their intention that all doctors will participate in this learning during their training at both undergraduate and postgraduate levels, and for continual professional development, while also remaining available for all other members of the healthcare workforce (Institute for Innovation and Improvement, 2011). Although this framework is aimed at both clinical and managerial leadership, it offers some but not all transferrable qualities to those required strictly for business management and leadership. However, it is also worth noting that the NHS Institute is currently reviewing this framework as a result of the recent changes to the NHS, and expected further changes to the NHS in the coming years.

Ginzberg and Vojta (1981) as seen in Boyatzis (1982) define human capital as 'skill, dexterity, and knowledge' for which return on investment (ROI) can be realised, and this realisation is achieved through models of management. However, the accuracy and usefulness of a model of management is dependent upon the participant's understanding of the intentions behind that model (Boyatzis, 1982). If the model was generated through discussions by, for example, the leadership team, then caution must be taken, as people using the model are often left to use their own personal interpretations.

It is widely agreed that there is no specific way to manage or lead (Boyatzis, 1982; Mintzberg 2011), and that competency models span the continuum from

‘scientific management’ to ‘humanistic management’. Boyatzis (1982) proffers a framework based upon 5 clusters, which helps identify the underlying competencies which can be used to shape management methods across that continuum. These clusters are described as:

1. Goal and action management cluster *(entrepreneurial)*
2. Leadership cluster *(people stimulator)*
3. Human resource management cluster *(interpersonal)*
4. Directing subordinates cluster *(performance feedback)*
5. Focus on others cluster *(maturity)*

These clusters each have between three and four criteria within each competency rated across five levels: ‘*Motive’, ‘Trait’, ‘Self Image’, ‘Social Role’,* and *‘Skill’*.

The mapping across these clusters aids in the identification of where individuals sit on the ‘scientific management’ – ‘humanistic management’ continuum, and their development can therefore be targeted according to the chosen method of the organisation (Boyatzis, 1982). However, it is worth noting that other similar models have been developed such as Mintzberg (2011) style of managing in terms of art, craft and science, as seen in figure 9 below.

Figure 9 – Styles of Managing (Art, Craft and Science)

Source: Mintzberg (2011)

Mintzberg (2011) notes, that management requires a mix of styles, and has developed an instrument in collaboration with Beverly Partwell, [*and notes that you are welcome to use it*] (Mintzberg 2011, p.127), as seen in appendix six. This instrument allows individuals to plot their own style against the styles of art, craft and science, with the aim of being somewhere in the middle.

However, in terms of 'excellence' in management and leadership, Perren and Burgoyne (2002) as seen in Mumford and Gold (2004) set out a framework of eight components with a varying number of competencies for each; totalling eighty three:

1. Manage and Lead People
2. Think Strategically
3. Lead Direction and Culture
4. Manage Self
5. Manage Resources

6. Manage Information
7. Manage Activities and Quality
8. Manage Relationships

They also note that such frameworks (seen in appendix seven) fall into two categories: generic models and organisational-specific models, and suggest the latter is more commonly adopted in order to provide specific management development aligned to the needs of the organisational vision (Mumford and Gold, 2004).

Previous performance frameworks used within primary care have noted that most value comes from frameworks where measurements are linked to interest around a specific aspect or linked to education (Proctor and Campbell, 1999). The performance framework developed by Proctor and Campbell (1999), focussed upon seven organisational themes, which were derived from the outcomes of their study:

1. Patient experience
2. Clinical activity
3. Service development & innovation
4. Access
5. Health promotion
6. Cost effectiveness
7. Outcomes *(quality of life)*

The themes listed above covered a number of views, obtained from practice managers, nurses and general practitioners, and were seen as central to the overall evaluation of quality. The framework is perceived to be dynamic in terms of how each component interacts with all other components.

However, as GPs are perceived as senior leaders, a primary care competency framework requires director equivalent level competencies to be included, together with the more traditional management competencies (Coulson-Thomas, 2009). Although GPs transcend both levels of management and

leadership, a clear distinction between organisational direction and management is required (Coulson-Thomas, 2009; Mumford and Gold, 2004), so in the context of the senior role of GPs, competencies should be included that ensure they have knowledge about duties, liabilities and responsibilities (Renton and Watkinson, 2001; Webster, 2005) as seen in Coulson-Thomas (2009).

As leaders, if not owners of organisations, GP leadership competencies may well be more beneficial if they were to span the organisation systemically, to be seen as a property of the organisation not of the individual and where the leadership process is seen as more important than the leadership skill (Tate, 2013). This is further enabled through a challenge of paradigm, where 1) managing the people and 2) improving the system are carried out simultaneously.

In support of this idea, the National Occupational Standards (NOS) database offers a number of competency criteria to support all functions by all people across the organisation (NOS, 2008), for example the ‘management and leadership’ suite includes eighty eight standards (seen in appendix eight) and which each have four perspectives:

1. Performance Criteria
2. Knowledge and Understanding
3. Behaviours
4. Skills

Although these standards do not specifically distinguish between individual or organisational nor management or leadership, it does allow them to be drawn from, according to current need, while the remaining standards are available to inform further development.

Following on from the noted competency frameworks above, it must also be made clear who the leaders are from those with subordinate leadership responsibilities, and which responsibilities lie with whom. The unique scenario

within general practice, where GPs as partners/owners of the business may or may not undertake a leadership role must be made known across the whole organisation, and the position of GPs who are not partners/owners who may become involved in organisational leadership. Those GP partners/owners who do not take on a leadership role, must however still note their duties, responsibilities and liabilities as business owners (Renton and Watkinson, 2001; Webster, 2005) as seen in Coulson-Thomas (2009).

4.2.3 Derived Framework

By examining the literature and analysing existing models a new model emerged that took into consideration the requirements needed to develop a qualities framework for general practitioners, which covers both GPs as partners of a business and those as members of a clinical commissioning group.

GPs functioning through general practice are primarily contractors to the NHS, who are, to all intents and purposes, their main customer (Kings Fund, 2013). The function of general practice fits within the overall structure of the NHS, which already caters for the development of GPs as doctors through a number of registrations and colleges (JRCPTB, 2009). And as part of these developments, GPs are exposed to a number of qualities based frameworks from their clinical work, with many qualities capable of being transferred to a business perspective (Fones, Kua and Goh, 1998; Gruber and Frugone, 2011).

The derived qualities framework includes senior management competencies aimed at directors and senior leaders (Coulson-Thomas, 2009), together with existing core management competencies; many of which are transferrable from clinical frameworks. The qualities framework offers the majority of competencies needed, while allowing GPs to identify for themselves those additional competencies needed for senior leadership, such as: vision, strategy, analysis, constructive challenge and criticism, ethics, integrity,

courage, principle, duties, liabilities and responsibilities (Clark and Armit, 2010; Proctor and Campbell, 1999).

This framework aims to complement the existing GP curriculum and leadership education and training programme (JRCPTB, 2009) with the additional intention to suggest other qualities needed to deliver 21st Century healthcare, with the intention to direct the focus towards business innovation, creativity, and entrepreneurship (Proctor and Campbell, 1999).

Each of the domains and qualities from the frameworks identified in the foundation section of this chapter have been mapped together in relation to theory, producing a common set of domains and qualities, and adopted for use within this framework. This ensures depth and breadth across the management and leadership role:

Domains

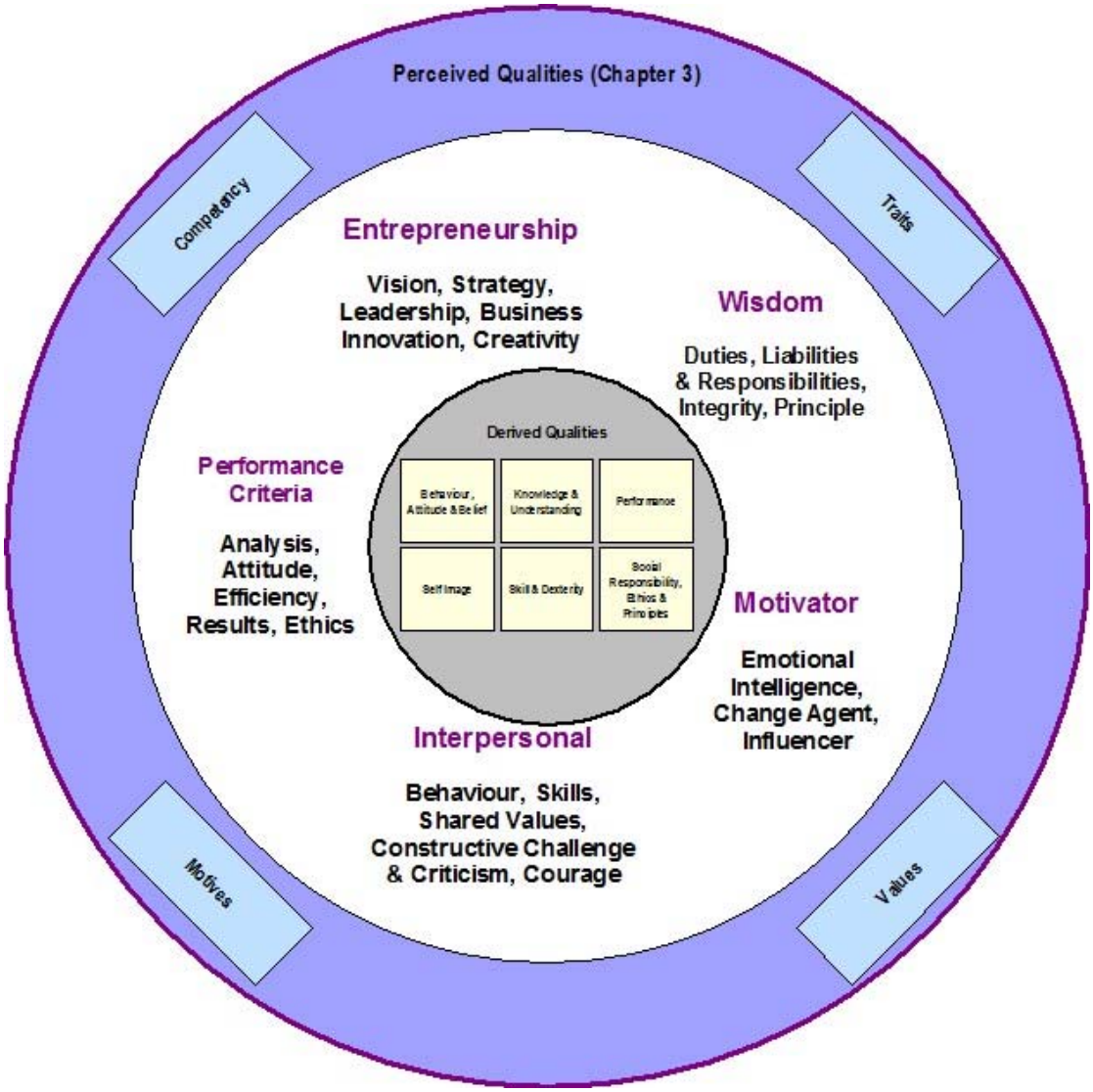
1. Analytical Ability
2. Developmental Capabilities
3. Innovation & Creativity
4. Leadership
5. Manage Self
6. Quality
7. Shared Values
8. Strategist
9. Working with Others

Qualities

1. Behaviour, Attitude & Belief
2. Knowledge & Understanding
3. Performance
4. Self Image
5. Skill & Dexterity
6. Social Responsibility, Ethics & Principles

Some of the key competencies such as entrepreneurship, wisdom, motivator, interpersonal and performance criteria identified from the derived framework (Boyatzis, 1982; Clark and Armit, 2010; Mintzberg, 2011; Mumford and Gold, 2004; Proctor and Campbell, 1999) have been used to demonstrate how the four qualities within the framework, seen in figure 8 above, and represented by the outer circle in figure 10 below; competency; traits; values; and motives; relate to the derived qualities; Behaviour, Attitude & Belief; Performance; Self Image; Skill & Dexterity; and Social Responsibility, Ethics & Principles, represented by the inner circle, which can be seen in figure 10 below.

Figure 10 – Derived Qualities



(Researchers own model)

This diagram demonstrates the key rationale behind the derived framework, with each of the qualities described in more detail below. Each of the derived qualities is described below in relation to their meaning, as applied, to the derived qualities framework.

Behaviour, Attitude & Belief – [Quality]

Such qualities stem from an individual's concept of themselves, which should be aligned to the perception of others, especially in multi-partner general practice, in terms of how they apply themselves to the task in hand, in line with the shared values of the group/organisation (Boyatzis, 1982).

Knowledge & Understanding - [Quality]

This refers to an individual's capability to understand the details of a task which falls out from their knowledge of the theory supporting it, termed "theory in use" by Argyris and Schon (1974), as a result of human values and interests (Schon, 1991).

Performance - [Quality]

The ability to demonstrate positively the adequacy of one's competencies (Mumford and Gold, 2004) while organising tasks (Boyatzis, 1982) in relation to the organisational plan, and also in relation to others.

Self Image - [Quality]

The personal interpretation of how one perceives themselves in relation to shared values within their organisation, and premised upon their own beliefs, and those of their peers (Boyatzis, 1982), and subject to one's own opinion and judgement of their own personality (Gross, 2010).

Skill & Dexterity - [Quality]

Having the ability to understand theory and technique (Schon, 1991) while problem solving organisational issues, as an individual or as a member of a multi-partner general practice.

Social Responsibility, Ethics & Principles - [Quality]

As an individual or as a member of a multi-partner general practice having the ability to understand the issues and accepting accountability for those issues relating to the wider context of society (Mintzberg, 2011) while obtaining appropriate consent/informed consent; not entering into deception; protection of participants; and offering debriefing and confidentiality (Gross, 2010).

The above qualities summary is designed to offer an explanation as to how each of the following domains should be interpreted when an individual reflects upon their own competencies, while mapping themselves in conjunction with their organisation, to the qualities framework as seen in figure 22 below.

In terms of each domain below, individuals should categorise themselves into three simple levels: basic; intermediate; and advanced, in terms of each competency within the domain, leading to an overall rating of basic, intermediate or advanced for the domain itself.

Analytical Ability – [Domain]

The ability to analyse organisational activities and impact underlies all other domains, in that desired outcomes must be met within the operating framework of the organisation to maintain stability and viability (Boyatzis, 1982; Wickramasinghe and De Zoyza, 2009). Individuals at all levels should have the capability to contribute to this domain.

Although general practice tends to not look to maximise its income over the care of the patients, under the new NHS, general practice must look to transparently maximise efficiency in its delivery of primary healthcare as the new holders of the healthcare budget (Department of Health, 2003).

See table 6 below for a non-exhaustive summary of competencies to be considered when reviewing an individual’s capability to contribute to the domain.

Table 6 – Analytical Ability Competences

Accountability	Efficiency orientation
Accounting and finance	Financial responsibility
Achievement of results	Governance effectiveness
Achievement orientation	Initiative and achievement orientation
Attitude to meet targets	Outcomes
Concern with impact	Results-orientation
Cost consciousness	Return On Investment
Cost effectiveness	Risk Assessment
Diagnostic use of concepts	

Developmental Capabilities - [Domain]

Each organisation should have a vision, and mission to achieve that vision. The developmental domain is used to ensure the preparedness of the organisation to execute the mission (Mintzberg, 2011; Proctor and Campbell, 1999; Weick, Sutcliffe and Obstfeld, 2008). With the onset of federated general practice, GPs would benefit from understanding and developing their organisational business processes.

See table 7 below for a non-exhaustive summary of competencies to be considered when reviewing an individual's capability to contribute to the domain.

Table 7 – Developmental Capabilities Competences

Business Skills	Management
Change handling skills	Marketing and sales
Customer focus	Planning and scheduling
Diversity consciousness	Structure
Education	Technical competence
Improvements	Technology management
Learning	

Innovation & Creativity - [Domain]

Following the typical life cycle of products and services, organisations would benefit from continued innovation and creativity in the development of new and emerging products and services, sometimes termed '*in the pipeline*' (Clark and Armit, 2010; Mumford and Gold, 2004; Proctor and Campbell, 1999). Although primary care deals with patient healthcare, and the expected life cycle of this service does not appear to have an end, there almost certainly will be an end to the method in which the service is delivered, and/or commissioned.

See table 8 below for a non-exhaustive summary of competencies to be considered when reviewing an individual's capability to contribute to the domain.

Table 8 – Innovation & Creativity Competences

Access	Problem-solving
Activity	Promotion
Creativity	Resources
Customer service	Services
Information	Spontaneity
Innovation	

Leadership - [Domain]

All organisations require a leader, with a number of leadership styles to choose from (with the exception of a few, such as co-operatives etc, but these will not be discussed here, as outside of the scope of this project). However, leadership may not be one single person, as in the typical configuration of primary care organisations, there are likely to be several as part of a partnership (Boyatzis, 1982; Coulson-Thomas, 2009; Proctor and Campbell, 1999). Systemic leadership implies a number of participants are involved with organisational leadership where each will take ownership of certain tasks, and therefore may need to achieve advanced levels in particular competencies and only a basic understanding in others.

See table 9 below for a non-exhaustive summary of competencies to be considered when reviewing an individual's capability to contribute to the domain.

Table 9 – Leadership Competences

Being inspirational	Legal
Belief	Liabilities
Coaching ability	Logical thought
Culture	Moral
Decision Making	Positive regard
Direction	Proactively
Duties	Responsibilities
Entrepreneurship	Stamina and adaptability
Flexibility	Transparency
Leadership	

Manage Self - [Domain]

This domain covers both the individual and the needs of the organisation, in terms of person fit. When delivering a strategy all individuals will take an operational share, and their fit has far reaching consequences, as their

actions are interdependent upon other individual's actions (Clark and Armit, 2010; Mintzberg, 2011; Mumford and Gold, 2004). As primary care organisations are expected to collaborate in the delivery of healthcare services in the community, GPs would benefit from obtaining competencies in this domain.

See table 10 below for a non-exhaustive summary of competencies to be considered when reviewing an individual's capability to contribute to the domain.

Table 10 – Manage Self Competences

Accurate self-assessment	Oral communication
Adaptability	Positive outlook
Autonomy	Pressure management skills
Beneficence	Principle
Common Sense	Resiliency
Communication Skills	Risk taking
Courage	Self-confidence
Emotional intelligence	Self-control
Emotional self-control	Self-knowledge of strengths and weaknesses
Example	Selflessness
Honesty	Stress management
Humour	Tact
Independent critical learner	Team player
Integrity	Time management
Interpersonal skills	Use of oral presentations
Listening Skills	Use of socialised power
non-Malfeasance	Use of unilateral power
Objectivity	Wisdom
Openness	Written communication

Quality - [Domain]

This domain covers how an organisation carries out its functions, in that these functions are both safe and efficient. Effective quality processes can considerably improve productivity and return on investment (ROI) (Ginzberg and Vojta, 1981) as seen in Boyatzis (1982).

GPs already have extensive exposure to quality standards within healthcare, and many competencies will be transferrable.

See table 11 below for a non-exhaustive summary of competencies to be considered when reviewing an individual's capability to contribute to the domain.

Table 11 – Quality Competences

Environmental responsibility	Experience
Ethical	Quality focus
Excellence	Safety focus

Shared Values - [Domain]

High quality organisations look to the sharing of values across the whole team to limit conflict and achieve a high level of coexistence (Perren and Burgoyne, 2002) as seen in Mumford and Gold (2004). With the likelihood of general practices federating to deliver clinical services within their community, it would be beneficial to obtain advanced competencies which may be used to span all federating organisations.

See table 12 below for a non-exhaustive summary of competencies to be considered when reviewing an individual's capability to contribute to the domain.

Table 12 – Shared Values Competences

Altruism	Moral
Image & Identity	Perceptual objectivity
Judgement	Team focussed
Justice	

Strategist - [Domain]

All good leaders have the ability to envision the aims of their organisation. GPs as leaders of primary care organisations must now look to envision their organisational fit to the new and emerging NHS (Proctor and Campbell, 1999). Development of an understanding of future developments of the NHS would benefit primary care organisations and help ensure their survival.

See table 13 below for a non-exhaustive summary of competencies to be considered when reviewing an individual's capability to contribute to the domain.

Table 13 – Strategist Competences

Being visionary	Positive vision
Boardroom contribution	Setting vision
Conceptualisation	Strategic Awareness
Direction	Strategic Perception
Goal setting	Strategic Thinker
Political and organisational awareness	Vision

Working with Others - [Domain]

Understanding key stakeholders is crucial to any organisation, such as patients (in terms of healthcare), staff, suppliers and partner organisations (Boyatzis, 1982; Mintzberg, 2011; Wickramasinghe and De Zoyza, 2009). The NHS is seeing some unprecedented changes, which is having an effect on

how primary care delivers its services. Having the ability to build relationships with key stakeholders may prove paramount to the continued existence of general practice (Proctor and Campbell, 1999).

See table 14 below for a non-exhaustive summary of competencies to be considered when reviewing an individual's capability to contribute to the domain.

Table 14 – Working with Others Competences

Accountability	Empathy to others
Being a change agent	Employee performance management
Being collaborative (team player)	Empowerment
Change management	Holistic
Concern with close relationships	HRM
Conflict management	Influencing skills
Constructive Challenging	Interaction with others
Constructive Criticism	Managing group process
Customer Focus	Negotiation
Customer relations knowledge	Relationships
Developing others	Service to community
Directing others	Team leadership

Through the development of these competencies, individuals can expect to obtain high command over each of the nine domains, and therefore when evaluating their qualities across each of the domains, both a clearer understanding of organisational fit and personal confidence will be seen.

4.3 Summary

This chapter has introduced a conceptual framework to aid in the understanding of the perceived problem from a general practice perspective. By first looking at the foundation to a qualities framework required by existing and emerging general practitioners, followed by a review of a number of related frameworks the researcher offers some illumination to support the development of a ‘general practitioner based qualities framework’.

The qualities and domains discussed in this chapter may subsequently be mapped on to the qualities framework matrix as seen in figure 22 below, which may be further used to focus an individual’s attention to areas in need of further development.

The next chapter discusses the adopted methodological philosophy and strategy.

5 Methodological Philosophy & Strategy

5.1 Introduction

This chapter looks at the philosophy and strategy behind the researcher's methodology used during the completion of this research project, which takes an inductive approach with an idealist ontology, interpretivist epistemology and abductive research strategy (these terms will be explained further within this chapter) in the answering of the following research question:

> ***What management and leadership qualities would enable primary care GPs to deliver "The Operating Framework for the NHS in England 2012/13, and beyond"?***

Drawing on this research the researcher aims to gain a better understanding of management and leadership qualities held by general practitioners in their rapidly developing role as providers, alongside their new membership role as primary healthcare commissioners. Focus is given towards the underpinning facets required of GPs to develop primary healthcare services, from a general practice business perspective, which due to the nature of interpretation of how this may be achieved, aligns to the use of a qualitative research approach.

Through this research the researcher aims to develop a qualities framework for use by prospective and developing GPs in progression of their future career paths. The researcher also hopes to inspire readers to continue research in this area.

5.2 Philosophy

5.2.1 World View

When considering an appropriate 'world view' (*sometimes referred to, as Weltanschauung*) which is based upon one's basic beliefs of the subject under review and one where its conclusion is unlikely to be proven factually or

logically, then in order to argue its case, an axiom must be espoused in terms of its relative truth. This is true for this qualitative research project which adopts an interpretivist view of how individuals make assumptions about the world in which they live or work (Creswell, 2009; Stokes, 2011). There are three approaches when considering one's world view: qualitative, quantitative and mixed methods (Creswell, 2009). The researcher has opted to follow a social constructivism perspective which explores and understands meaning behind human actions, which allies to a qualitative approach, relying on the participant's view of the situation.

The social constructivist perspective seeks meaning from a phenomenon from the views of participants (Creswell, 2009) through an interpretivist epistemology. The interpretivist epistemology refers to a methodological approach which hunts for the meanings that emerge from any given field of study (Stokes, 2011). Epistemology is the term given to how theories and knowledge are constructed (Stokes, 2011).

When considering the starting point of reason behind the research question, which aims to understand how GPs have developed their personal qualities in relation to business leadership and management, thus far, and how they have come to their conclusions/decisions about their career choices, it becomes clear that the answer lies within GPs as social actors going about their business, seen through the decisions they make (Aaltio-Marjosola and Takala, 2000; Whiteman, Muller and Johnson, 2009). Gaining an understanding of such a subjective topic supports the use of qualitative research (Creswell, 2009; Hines, 2000), where the researcher is required to take an 'insider' stance, as the research is interested in what is in people's heads, and their behaviour expressed as a result. The researcher has chosen not to take a deductive quantitative approach, as this does not offer the ability to gain an understanding from the subject under review, due to its scientific nature of fact, which would be compromised owing to the infinite interpretations made by human opinion. As a researcher working within the topic area under review, and given the nature of the topic itself – 'personal qualities', the researcher has adopted a qualitative inductive approach, where inductivism

refers to the method of iterative data gathering upon how traits and characteristics may be formed (Blaikie, 2009; Stokes, 2011).

The adoption of an inductive approach allows an understanding of how GPs consider their role as managers/leaders, and more importantly, how they consider themselves in terms of business owners, without the likelihood that the subject would respond in a mechanistic or scientific manner and bias the data collection process (Saunders, Lewis and Thornhill, 2012). This is particularly useful in terms of context, where the researcher is interested in understanding why something is happening, while maintaining the ability to adjust for constraints as they arise (Easterby-Smith et al., 2008) as seen in Saunders, Lewis and Thornhill, (2012).

It was first intended to follow the subtle realist ontology based upon the researcher's belief in the existence of an external social reality, as suggested in the original research proposal; however it became apparent very early on that the intended research had a closer fit to the idealist ontology due to the researchers understanding that the subject has culture and that they hold their own interpretations upon their actions, and that the impression of being real is simply what they think is real (Blaikie, 2007; Randrup, 2003). Ontology refers to a division of philosophy that is associated with the nature of what is thought to be real (Blaikie, 2009), although the researcher takes a subjective approach to this in terms of the meaning behind the perception of truth (Stokes, 2011).

According to interpretivism which suggests the study of social phenomena requires an understanding of the social world that people have constructed, and which they reproduce through their continuing activities (Blaikie, 2007; Creswell, 2009), where to a degree, this also applies to how the reality of an external world is accepted, and if accepted, whether or not it has an authority over the ideas that people have about their nature of the social world. GPs engaging in their own social roles in particular ways and with particular behaviours are interpreted in accordance with their own set of meanings, which comes from one of the intellectual traditions, phenomenology, which is described by Saunders, Lewis and Thornhill, (2012) as the way in which we

make sense of the world around us (Creswell, 2009; Fisher, 2010; Gill and Johnson, 2010).

Fisher, (2010, p. 300) describes the Abductive research strategy in an interesting manner:

> *"Abduction means kidnapping... by raiding your store of knowledge and reading, to hunt for a possible cause of the problem... You 'kidnap' that idea as a possible explanation."*

This description explains accurately the overall strategy adopted for this research project, where the researcher intends to hunt for possible underlying qualities of GPs, and then interpret them in conjunction with the emerging information coming from the literature around NHS reforms (Blaikie, 2007; Boyatzis, 1998). The research first describes the GP qualities and concepts identified, and then derive a number of domains and ideas in the form of a qualities framework that can offer an understanding to the problem. This Abductive research strategy naturally fits with the adopted idealist ontology and interpretivist epistemology (Creswell, 2009). Abductive research strategy refers to the investigation of social actors in their social world and the construction of their tacit reality.

5.2.2 Approach

In order to obtain a discernment of the research topic, it is suggested that a collection of data is required which allows an understanding to be developed, which can then be used to underpin the theory (Creswell, 2009; Gill and Johnson, 2010; Saunders, Lewis and Thornhill, 2012). Following this idea, the data methods adopted are presented through a number of, unstructured exploratory qualitative research methods including: questionnaires, focus groups, and interviews, coupled with a search of the literature. These methods fit with the inductive approach for developing theories (Creswell, 2009).

The use of questionnaires has been considered as a form of maximising data within a short space of time however consideration has also been made as to the type of questions included. The use of ‘white space’ for participants to record their views and opinions, attached to each of the closed questions, allowed for the potential to obtain ‘experiences’ from the answer, rather than a binary result in the form of yes or no (Gill and Johnson, 2010). Another form of collecting a large number of experiences in a short period of time comes from the use of focus groups (Crowley and Gilreath, 2002; Fisher, 2010; Hines, 2000; Saunders, Lewis and Thornhill, 2012). Holding sessions with multiple people allows for both interaction between the participants, which draws out deeper experiences than if they were on their own, and the ability to collect multiple responses at the same time. However caution is needed as participants may withhold information as they may not want to share their experiences with colleagues (Gill and Johnson, 2010).

A more time consuming instrument but remaining most insightful is interviews, which offers a unique insight into an individual’s experiences and opinions while presenting the researcher an exclusive opportunity to probe these experiences and opinions further (Crowley and Gilreath, 2002; Hines, 2000; Saunders, Lewis and Thornhill, 2012). The choice of environment may also influence the outcomes, as individuals appear to open up more when they are in a comfortable surrounding (Fisher, 2010). Meanwhile, literature reviews offer a broad collection of data through the use of key words and phrases, while searching peer reviewed articles. This gives the researcher the ability to identify empirical data which would not normally materialise. However caution is recommended as not all results may be peer reviewed, and may offer incorrect or unsubstantiated information (Saunders, Lewis and Thornhill, 2012).

Two main ontological views have been identified by Saunders, Lewis and Thornhill (2012): objectivism and subjectivism. Objectivism portrays the position that social entities exist in reality external to social actors, and subjectivism is viewed as social phenomena created from the perceptions and consequent actions of social actors. Due to the underpinning facets identified

in the make-up of GP qualities, seen in the framework in figure 8, in support of the new Health and Social Care Act 2012 it could be argued that an idealist view is being taken. Although, originally it was proposed that a ‘subtle realist’ ontology would be taken when presenting the research proposal to this thesis, the lack of depth found within this ontology did not allow for the research to make full representation of the topic under review. As the interaction with the participants aimed to take an overall view of their experiences and form a reality, based upon what those participants thought was real (Blaikie, 2007), the researcher’s view of the participants experiences being taken in the perspective of the individual, suggests that the idealist ontology appears more that of the perspective-idealist ontology, which refers to the subcategory of the idealist ontology concerned with making sense of an external world.

Epistemology is concerned with what constitutes acceptable knowledge in a field of study, as stated by Saunders, Lewis and Thornhill (2012), which can be further broken into several philosophies: positivism, realism and interpretivism, whereas Hines (2000) states that researchers often take two diametrically opposing philosophical stances (positivism and interpretivism) regarded as two poles on a methodological continuum. Positivism following the traditional scientific approach, used as a method to interpret results through measurement of variables in the data, being the quantitative approach; while interpretivism being a subjective approach aiming to understand meaning, context and complexity. From this description, it can be seen that an interpretivist epistemology has been taken as the researcher’s understanding is derived from people making sense of their activities (Blaikie, 2009; Gill and Johnson, 2010), and where an explanation of human behaviour is derived from the sense and elucidation of those conscious actors who are being studied through emic analysis (Gill and Johnson, 2010).

As the research aims to collect data through a selection of research instruments, such as questionnaires, focus groups and interviews, some generalisations can then be derived which will support an explanation as to the future needs of GPs in their role as business leaders. This scheme lends itself to the inductive research strategy (Blaikie, 2007), as outlined in the

original research proposal. However, the research also aims to look deeper into the data collected, by understanding the meaning behind the data in terms of social perception and tacit knowledge held by social actors participating in the study, which required a shift in adopted strategy to that of an Abductive research strategy. This research strategy is classically used by the interpretivist paradigm to produce scientific accounts of social life by drawing on the concepts and meanings used by social actors and the activities in which they engage (Blaikie, 2007). Access to any social world by the accounts given by the people who inhabit it also contains the concepts that people structure their world, their meanings and interpretations, and the motives and intentions which people use in their everyday lives and which direct their behaviour. Abduction/Interpretivism acknowledges that human behaviour depends on how individuals interpret the conditions in which they find themselves and accepts that it is essential to have a description of the social world on its own terms. It is the task of the social scientist to discover and describe this world from an 'insider' view and not *impose* an 'outsider' view. Everyday life is studied in its own terms, the individuals understanding, and only methods of observation and analysis that retain the integrity of the phenomena should be used.

Abduction was applied when attempting to move from lay accounts of everyday life of GPs, to a description of their social life. It is a developing strategy with on-going debate on how best to move from lay language to descriptive language. There are differences of opinion with regard to retaining the integrity of the phenomena when moving from people's views and explanations, to social scientists' interpretations (Fisher, 2010; Randrup, 2003). The Abductive strategy has many layers to it, although there is some difficulty in proceeding to the final stage in which social theories might be generated from people's views and explanations or that these social scientific interpretations can be understood in terms of social theories and perspectives, leading to the possibility of an explanation or a prediction. However, some positions argue that the research should go no further than to sort through, devise categories for and pigeon hole the various constructs provided by the social actors within the study. The Abductive/Interpretivist strategy has been

advocated as either the only approach for social sciences, or an adjunct to other strategies (Blaikie, 2007; Fisher, 2010).

The research approach focuses initially on the collection of primary data used to inform the project of current and emerging ideas in relation to the development of a qualities framework for use by developing and prospective GPs in their chosen career paths. Development/redesign of healthcare services are subjective (due to the nature of the NHS dealing with people not technology) and based upon many business and clinical facets; therefore a predominantly qualitative approach has been adopted based upon the suitability towards the type of topic reviewed (Cassell, Buehring, Symon and Johnson, 2006; Fisher, 2010; Hewison, 2003; Saunders, Lewis and Thornhill, 2012).

5.3 Strategy

5.3.1 Purpose

The following purpose statement is designed to establish the objective of the whole research study (Creswell, 2009):

> The purpose of this qualitative study is to understand whether doctors consider their role as business leaders when choosing to become a general practitioner (GP), and if so, how they gain business skills and knowledge to support this decision, or not. By adopting an ‘insider’ stance to understand GP personal qualities, it allows the study to focus upon the GP role within the context of their position as general practice leaders/owners holding a contract to deliver primary healthcare services to the UK NHS from a business perspective. Methods of inquiry result in interpretations of sourced data to be used to develop a qualities framework for existing and emerging GPs to employ in support of their career development pathways.

5.3.2 Methods

This qualitative study utilises a number of methods of inquiry, data collection, analysis, and interpretation to support the development of a qualities framework for use by existing and emerging general practitioners. The researcher undertook an 'insider' stance which allowed for a sustained and concentrated experience with the participants; general practitioners (GPs). This primary data study was carried out within the natural environment of GPs with pre-existing relationships between the participants and the researcher, with the exception of the data collected by questionnaires, although the majority of these respondents have access to the researcher's identity through the social groups the questionnaires were circulated within.

Considered Methods

A number of primary data and secondary data research methods have been considered with the aim of covering all relevant aspects of the study.
The primary data approach observation allows the researcher to sit, watch and listen to events happening around them (Fisher, 2010). However, this method has some drawbacks, in terms of the observed becoming self-conscious and therefore not acting normally. Care must be taken as to the ethical issues surrounding observation, and the agreement required by the observed. Observation may also be made through the use of video or audio recordings (Cassell, Buehring, Symon and Johnson, 2006; Fisher, 2010). Once the observed overcome any self-conscious issues, this form of research can offer unique insights into GP personal qualities (Fisher, 2010).

Questionnaires however, are intended to be self-administered, get to the point quickly and provide 'as is' answers while also offering the participant the ability to include their individual viewpoint (Hewison, 2003). The design of the questionnaire may influence participant responses and as such, caution should be given to the choice of questions offered, which can be made up from closed questions which probe respondents about aspects pertinent to the topic. However open questions may gain deeper insights, subject to the desired outcomes (Saunders, Lewis and Thornhill, 2012). Sufficient numbers

should be sent to as many respondents as possible to ensure that the number of returns is useful.

The focus group is a well-known and widely used method; usually comprising of a group of four to six people whose purpose is to express their understanding and experience of a given topic; this method can provide insightful information in a short period of time (Fisher, 2010). The overall aim is to expose the meanings and ways of understanding that members of the group bring to their experiences of the events and circumstances of relevance to the research (Dickson, Rainey and Hargie, 2003a).

One to one interviews usually requires a significant number of interviews to take place to cover the wide range of perspectives required across the varying levels of key participants, and as such requires a considerable amount of time to complete (Fisher. 2010). However, by utilising a familiar environment, participants can come to reflect quite deeply on the questions giving the researcher depth in their responses (Cassell, Buehring, Symon and Johnson, 2006).

Social Network Analysis (SNA) can offer a useful dimension of related activity when used as a business tool for understanding communications, posted in real time by individuals, who have the need to express their opinion, based upon their current interaction with the topic. This usually takes the form of an individual's email sent to a list server for viewing by many, who in turn can respond in an individualistic manner, or through the use of facebook and twitter. Dickson, Rainey and Hargie (2003b) state that among others, an advantage is that SNA identifies patterns allowing inter-group relations to improve outcomes.

The secondary data approach, 'Documentary' requires access to written material such as emails, minutes of meetings, notices, reports, speeches, diaries, books, magazines and newspapers (Saunders, Lewis and Thornhill, 2012) which can be a great source of data when looking for instances of similar results such as key words or phrases. Fisher (2010) notes that this

form of research has proven popular in management circles, for example, when counting the number of articles and papers relating to the topic under review.

Chosen Methods

The use of questionnaires brings an aspect of greater efficiency for the researcher. It is generally agreed that questionnaires are best suited to asking specific rather than general questions, and closed rather than open questions (Robson 1993) as (cited in Barnes 2001), and as such gives a balance to the focus group method. Although this suggests a quantitative approach and does not take into consideration the target audience state of mind, or working pressures when completing the questionnaire and assumes the results rightly or wrongly as fact. Fisher (2010, p. 240) reminds us of a quote from Rowntree (1991) *"As a consumer of statistics, act with caution; as a producer, act with integrity".* Opting to use additional 'white space' linked to each question however, allows the researcher to obtain meaning from the responses, which fits well with this study.

The focus group method has been chosen as one of the most appropriate instruments to identify qualitative data in support of subjective topics such as management and leadership. Merton and Lazersfield as cited in (Hines, 2000) have been attributed for their development of the 'focus group' method, first termed "focus research"; used for social understanding of war-related communications. Dreachslin (1999) states that this technique offers several advantages over other techniques; among them are the following (Dreachslin 1999, p. 226):

- Peer interaction provides a social context for participant input that is lacking in individual interviews.
- Cost per respondent is less than with individual interviews.
- The open-ended questioning format affords the flexibility to pursue ideas through probes and pauses in ways that closed response survey techniques do not permit.

These advantages largely reinforce the decision to adopt this technique as a research instrument.

McClelland (1994) however, states that focus groups are rarely used as stand-alone approaches and are used in conjunction with other types of data gathering methods such as questionnaires and individual interviews. In support of the focus group method, peer interaction is used as a powerful tool; described by Krueger (1994) as cited in (Dreachslin 1999, p. 226):

> *The focus group interview works because it taps into human tendencies. Attitudes and perceptions relating to concepts, products, services or programs are developed in part by interaction with other people. We are a product of our environment and are influenced by people around us... Often the questions asked in a focused interview are deceptively simple. They are the kinds of questions an individual could answer in a couple of minutes. When questions are asked in a group environment and nourished by skilful probing, the results are candid portraits of customer perceptions.*

Non standardised, one-to-one, face to face interviews support the need for explanatory studies where the researcher aims to infer causal relationships between variables, (Saunders, Lewis and Thornhill, 2012). This enables an understanding of the reasons participants take, and to further understand their attitudes and opinions. It also allows the researcher to probe answers, building on the participants' responses, and fully understanding their meanings.

Justification

Questionnaires offer the capability to obtain bulk information in a short timescale, while also allowing the participant to share their opinions and support the data obtained through other research instruments. Owing to the use of 'white space' linked to each question for this study, the responses benefit from qualitative analysis through methods such as thematic analysis in addition to the quantitative numerical data that questionnaires offer.

Subject to the participants being familiar with each other, and holding no personal reservations to GP personal qualities, focus groups become a useful method of data collection. Also being a well established technique which allows the researcher to observe interactive practices first hand, and its adaptability to cross multiple contexts when exploring initial ideas and hypothesis. An in-depth study of experiences, feelings, attitudes, and opinions can be gained through the interaction of the group which can otherwise be missed in methods such as questionnaires. The focus group ultimately gives the researcher a lot of information in one sitting.

Owing to the study requiring the participants to reflect upon past activities, the use of interviews, when carried out in a private and familiar environment, allows the researcher to probe particular aspects which may not be seen in other research instruments.

Rejected Methods

The method of observation, due to the nature of a GPs role, where they spend the majority of their time with patients, and the ethical issues of observing GPs in that situation did not justify its use. In addition, much of the research data did not require the observation of GPs, in action, as the study is more interested in their reflective responses to their life-long journey, and their derived ability to demonstrate leadership and management skills.

Due to the subject matter requiring retrospective data, it is highly unlikely that social network analysis data would exist within the target group, and given the nature of the topic being researched, general practitioner confidentiality is paramount and as such cannot be promoted via this type of tool. As the main role of a GP is to offer clinical advice and support to patients, it is also considered highly unlikely that they would be participating in appropriate SNA forums where such data could be taken.

Although documentary secondary data research can prove useful in qualitative research, it is better used for quantitative and/or numerical research owing to the statistical nature of the results, where for example

counts of findings are used to inform a range of use. As the study is looking for meaning behind the topic, documentary evidence is unlikely to be useful. The researcher could not identify a reliable source of GPs participating in such methods of data collection; including, emails, letters, notices, minutes of meetings, diaries etc, relating to leadership and management, so would not offer a true and clear picture.

5.3.3 Analysis

The qualitative methods adopted for data collection, being based upon meaning and opinion, requires the analysis process to make sense out of that data, described as ‘peeling back the layers of an onion’ as seen in Creswell (2009), by understanding, interpreting and concluding meaning of that data. From that data, themes or perspectives may be identified from significant statements, the generation of meaning, and the development of essence description, as suggested by Moustakas (1994) as seen in Creswell (2009).

Use of the NVIVO software application enables electronic documents, including any free text the participant chooses to enter to be recorded. Focus groups and one to one interviews that have been audio recorded for transcription may also be added later. Transcription notes which include non-verbal communications to give an additional aspect to the discussion, in terms of nervousness, laughter or annoyance, may also be added to the NVIVO application (Saunders, Lewis and Thornhill, 2012).

Creswell (2009) offers the following data analysis process, seen in figure 11 below, which suggests a linear, hierarchical approach to data analysis.

Figure 11 – Data Analysis in Qualitative Research

Source: Creswell (2009)

Once data has been added to NVIVO, themes may be coded across all data items using an appropriate coding classification system which allows descriptions to be generated, from which a narrative can be made, leading to a final interpretation of the data (Creswell, 2009; Saunders, Lewis and Thornhill, 2012). Throughout this process the researcher may iteratively test for data validity.

5.4 Summary

This chapter has introduced the methodological philosophy and strategy used to describe the researcher's world view (*Weltanschauung*), as a qualitative

researcher. An inductive approach following an interpretivist epistemology with an idealist ontology has been taken forming an Abductive research strategy.

The purpose of the strategy gives an outline of how the researcher prepares to answer the research question, through the use of a number of qualitative research instruments used to collect data. An explanation of how the data may be analysed is made, which allows for final interpretations to be laid out.

The next chapter discusses the research method design, which explains in more detail the research instruments and its reliability and validity, while also covering the researcher’s ethical position.

6 Research Method Design

6.1 Introduction

This chapter looks at the research method design in support of this qualitative study, which provides an in-depth discussion of the construction of research instruments and their linkage to the framework/theory seen in figure 8 above (Johnson, Buehring, Cassell and Symon, 2007; Hewison, 2003; Saunders, Lewis and Thornhill, 2012). It continues with an explanation of ‘reliability’ of data collection techniques used to ensure consistent results, followed by further discussion around validity in terms of causal relationships, and then discusses the use of different data collection techniques which allows for triangulation to be carried out ensuring a comprehensive, thorough and complete study has been undertaken, leaving no room for inconsistencies (Williams and Gunter, 2006).

The chapter concludes with a discussion of ethical considerations of the research contributors, and clarifies how the researcher attempts to protect the participants at all stages of the study.

6.2 Construction

6.2.1 Research Instruments Design

Due to the need to gain an understanding of general practitioners (GPs) ‘qualities’, being a subjective topic, requires the research instruments to take the form of semi-structured/unstructured exploratory research. Although, as Pope and Mays (n.d.) as seen in Gatrell and White (1996) suggests that clinicians, especially doctors, owing to their training, tend to relate better to statistical based research, and can be sceptical of more qualitative methods. However, by taking a more structured approach it would limit the participants’ capability to share their personal opinions and views, due to the fact that in a positivistic methodology, structured research instruments would continually redirect participants back to the pre-supposed outcomes previously prepared

by the researcher (Fisher, 2010; Gatrell and White, 1996; Saunders, Lewis and Thornhill, 2012), and which would not allow the emergence of ‘meaning’ behind the responses to be seen.

To maximise this data, three substantive research instruments were adopted: questionnaires, focus groups, and one to one interviews, which in addition to offering great insights into the participant’s views and opinions, also allows for triangulation of results (Crowley and Gilreath, 2002; Williams and Gunter, 2006; Wright, 1996).

The participant target cohort covers a mix of general practitioners spanning all levels of leadership and management roles, in terms of GP partner, Salaried GP, locum GP, GP Registrar, and Clinical Commissioning Group (CCG) board member GP.

Initially, this primary research intended to carry out two focus groups with four to six GPs respectively, with further interviews aimed at senior GPs, and a questionnaire aimed at a wider general practitioner audience. However, due to the inability to coordinate a number of GPs attendance at these focus groups, due to limitations to their availability, a decision was made to hold only the first focus group which comprised four general practitioners, and carry out additional interviews for the remaining GPs.

Questionnaire

The decision to use a questionnaire came from the need to obtain large amounts of data in a short period of time relating to how GPs see themselves in terms of having or requiring management and leadership qualities, and to offer the opportunity to triangulate the findings with other research instruments (Fisher, 2010; Saunders, Lewis and Thornhill, 2012). An assumption was made, that by taking the views of GPs directly, the findings would be more meaningful, and therefore agreeable to the profession.

The questionnaire design, as seen in appendix nine, focuses on education, and management and leadership questions required to answer the objectives

of this research as outlined in chapter 1 section 1.2 by providing answers relating to general practitioner; employment aspirations, business perspective, education perspective, primary healthcare and personal views relating to GP qualities, required to deliver 21st Century healthcare from a business perspective, with each question offering ‘white space’ to record supporting ‘meaning’ and further details.

The questionnaire was based upon the research question and key objectives, focussing on GP consideration of their role as business leaders, and consideration of their education to support this. It was broken into two sections: personal and work. The personal section collected the minimum amount of data deemed acceptable for the purposes of this study, with the work questions specifically focussed on the areas of study. Questions were worded so as to not receive ambiguous answers (Walonick, 2004).

In order to avoid annoyance and frustration a thorough review of the questions to be asked was taken which ensured they were applicable, which also kept the overall number of questions to a minimum to increase the likelihood of participants’ completion (Fisher, 2010; Frary, n.d.). The original questionnaire design was shared with colleagues for further refinement.
Closed questions made up the majority of the questionnaire to ensure respondent participation, although ‘white space’ was offered for all questions to capture further ‘meaning’ where possible as suggested by Brown and Bell (2005). The use of the often used option ‘other’ was omitted as to limit the potential for respondents to ignore a more appropriate answer when answering a choice question (Frary, n.d.; Walonick, 2004).

As suggested by Walonick (2004), consideration of the analysis process was given, to ensure the questionnaire asked questions for which the analysis relied, and that no ethics codes would be broken through the collection of personal data that was not explicitly requested (Brown and Bell, 2005).

In order for the researcher to maintain control over the responses the questionnaire was initially sent out to 100 GPs across the North West of

England which gave a return of 21 responses. To increase this number the questionnaire was then circulated across a number of additional electronic networks across the UK which brought the final total of responses to 50. The use of survey monkey was adopted to reduce cost, and to ease in the pulling together of the data following the data collection period.

Focus Group

The decision to utilise a focus group was made to help in maximising the data within a short period of time, while gaining a fuller understanding of 'meaning' behind the responses, in context, than could be obtained from the questionnaires alone (Crowley and Gilreath, 2002; Hines, 2000; Schmidt, 2001). This method allows the researcher to probe particular angles of enquiry which may not have been considered prior to the study (Saunders, Lewis and Thornhill, 2012). In addition, comments from multiple members taking part in the discussion may also trigger ideas and memories from other participants.

The focus group session discusses the participants' life-long journey in becoming a general practitioner, from childhood, through schooling, to university, medical school and their final decision to become a general practitioner, with final reflection upon their consideration of also becoming involved with small business, as seen in appendix ten. The discussion was recorded and transcribed for later detailed analysis with all identifiable comments removed. It was agreed that the participants will remain anonymous as to not give any indicated link to their personal data.

The session was held in a location which was familiar to all participants, and all participants knew each other which supported an open and honest discussion (Walonick, 2004; Wright, 1996). The researcher introduced the study and outlined the process, which gave enough time for the participants to relax prior to the first question (Schmidt, 2001; Walonick, 2004). The question order, as seen in appendix ten, was designed to follow the life of the participants from childhood to present day, and was worded as open questions (Crowley and Gilreath, 2002) to ensure a fuller response.

Each participant was encouraged to answer each question, and participate in the probing of each answer given by others, which increases the depth of conversation (Crowley and Gilreath, 2002; Hines, 2000). Wherever the topic digressed away from the study, the researcher brought the conversation back to the research question, which was used as the focus point first identified in the introduction to the focus group.

One to One Interviews

The decision to hold a number of one-to-one interviews was taken to help validate the findings from the questionnaire data collection exercise (Fisher, 2010; Saunders, Lewis and Thornhill, 2012; Wright, 1996). In addition, due to the difficulties in forming further focus groups, a decision was made to include those remaining participants, first identified to participate in a focus group to be included in this exercise. The interviews followed the same structure as the focus groups by discussing the participant's life-long journey in becoming a general practitioner, from childhood, through schooling, to university, medical school and their final decision to become a general practitioner, as seen in appendix ten.

Each interview was carried out in a place of the participant's choosing, which ensured a level of relaxation and comfort, allowing for the improved possibility of gaining a deeper insight in to their reflections (Wright, 1996). The discussion was recorded and transcribed for later detailed analysis, with all identifiable comments removed. It was also agreed that the participants will remain anonymous as to not give any indicated link to their personal data.

As with the focus group, the researcher introduced the study and outlined the process, which helped the participant to relax prior to the first question (Schmidt, 2001; Walonick, 2004). The question order, as seen in appendix ten, followed the life of the participant from childhood to present day, and made use of open questions (Crowley and Gilreath, 2002) to ensure a more complete response, and wherever the topic deviated from the study, the researcher brought the conversation back to the research question, which was used as the focus point first identified in the introduction.

Analysis

Upon completion of the above primary research, the use of thematic analysis aids in the identification of underlying competencies, traits, values and motives, as outlined in chapters 2, 3 and 4. This analysis aims to develop theory from the data collected by sorting data into categories, against specific criteria which requires more than a simple impressionistic view (Hewison, 2003; Saunders, Lewis and Thornhill, 2012) in terms of narrative and sense which supports meaningful findings.

The use of Computer Aided Qualitative Data Analysis Software (CAQDAS) 'NVIVO' is used to aid in the coding/classification of data; termed 'Nodes'. Each node describes what theme, pattern or relationship a response or comment identified within each of the transcripts and questionnaire responses relates to, for example, data, laughter, anger, proposition, suggestion, idea etc. These nodes derive categories in relation to the framework, as seen in figure 8, which can be further used to provide an emergent structure for further analysis (Saunders, Lewis and Thornhill, 2012).

6.2.2 Reliability

When collecting data from any research instrument, the results must lead to consistent findings, where Saunders, Lewis and Thornhill, (2012) suggest the following three questions:

1. Will the measures yield the same results on other occasions?
2. Will similar observations be reached by other observers?
3. Is there transparency in how sense was made from the raw data?

To ensure the most consistent results, the researcher takes in to consideration any participant bias in the responses by including a node to represent this within the NVIVO application, such as eagerness to please the researcher or, contradict the potential outcome. These reliability tests are designed to work in conjunction with the methods of validity seen below.

6.2.3 Validity

The use of the CAQDAS NVIVO assists the researcher in the identification of threats to validity by noting, for example, participant gestures when discussing GP management and leadership qualities, in light of the recent enforcement of the Health and Social Care Act 2012, and in relation to the future of general practice, and the effects this may have on GPs that work within and own them.

When classifying results of the research instruments, a rigorous approach to 'context' is taken, so as to not explain a result which answers a question that the research did not intend to answer. I.e. does the statement or construct measure the thing they are said to measure (Fisher, 2010).

A critique of the researcher's findings enables the final analysis to be credible, through the use of six principles, seen below, proposed by Winter (1989) as seen in Fisher (2010).

1. Reflexive critique – *where the reader is allowed insight into the researcher's thinking*
2. Dialectical critique – *identification of contradictions in the research findings*
3. Collaborative resources – *engaging stakeholders in the interpretation of the findings*
4. Risk to one's own values – *where the researcher is open to challenge of their interpretations*
5. Plural structure – *the recognition that findings may have multiple conclusions*
6. Theory, practice, transformation – *the application of theory in practice, and vice versa*

These six principles are applied throughout the data analysis exercise as supporting nodes within the NVIVO application, and through the write-up seen within this thesis. However, principle 3 has not yet taken place due the

restraints of this research study, although the researcher intends to share the findings with all face-to-face participants at a later time.

6.2.4 Triangulation

Although the study does not specifically employ a mixed methods research methodology, the use of questionnaires alongside the focus group and one to one interviews allows the collection of quantitative, or for the purposes of this study, and better termed ‘numerical data’, which can be used to identify convergence or differences in the data. However, the questionnaire was designed to collect both numerical and qualitative data through the use of pre-supposed answers in the form of multiple choice, and ‘white space’ attached to each question to support ‘meaning’ in those responses, which allows for cross referencing back to both the focus group and the one to one interviews.

The use of these complementary research techniques allows for a fuller explanation of the study, by minimising the potential for bias (Creswell, 2009; Gill and Johnson, 2010; Saunders, Lewis and Thornhill, 2012) and allowing for triangulation to be carried out ensuring a comprehensive, thorough and complete study has been undertaken, leaving no room for inconsistencies (Saunders, Lewis and Thornhill, 2012; Williams and Gunter, 2006).

6.3 Ethics

6.3.1 Ethical Considerations

Carrying out research within the NHS by definition is subject to ethical consideration. When accounting for morality and ethics within government, public and private sector organisations we are generally referring to the behaviour and collective outcome of actions taken by the leaders and their subordinates as described by McManus (2004). GPs as leaders must ensure that no breach of data is seen as a consequence of their actions, and the actions of their subordinates (Creswell, 2010; Gill and Johnson, 2010).

In addition, as citizens, we are all bound by a social contract, to act in particular ways towards each other and with regard to the instruments and institutions of law (Creswell, 2010; Gill and Johnson, 2010; Saunders, Lewis and Thornhill 2012). However, this social contract takes on additional burdens when applied to professions, beyond those expected of the individual member of society, for example, when applied to the medical profession, in terms of general practice, an additional rigorous code of ethics enters into the social contract so that GPs act in a proper manner, and one that is not detrimental towards its patients, and in return GPs receive recognition to the right to practice medicine (McManus, 2004).

As this research is aimed specifically at GPs, every effort is made to identify and address ethical dilemmas arising from this study, in terms of ethical considerations around the devaluing of participants in the eyes of their co-workers and/or partners, and to the NHS as a whole, with reference to participant's leadership and management skills, or in any other way that the research may disadvantage them, (Creswell 2009; Fisher 2007; Gill and Johnson, 2010; Saunders, Lewis and Thornhill 2012).

This study, in accordance with current guidance from the National Research Ethics Service (NRES) is exempt from full ethics approval, as seen in Research and knowledge transfer office (2011), also noted in the extract seen below, however the researcher continues to follow stringent ethics principles at all times.

> *Under the 2001 edition, REC review was required for research involving NHS staff recruited as research participants by virtue of their professional role. Such research, or equivalent research involving the staff of social care providers, is* ***excluded from the normal remit*** *of RECs under the harmonised edition of GAfREC.*

Following the refinement of research participants being limited to GPs only, and their status as independent contractors, this also removed the requirement to obtain ethical approval from NHS Manchester and its

subsequent replacement organisation, Central Manchester Clinical Commissioning Group (CMCCG), as first suggested in the research proposal; all participants were informed of this prior to commencement. In addition, all participants were given an information sheet, seen in appendix eleven, detailing the nature and purpose of the research and assuring them of anonymity and confidentiality. The researcher makes clear the methods of the focus groups and interviews and answers any questions while assuring participants that they do not have to participate; however if they do consent, they may still withdraw from the study at any time.

Every effort was made to ensure that no identifiable organisational, user or patient related data has been disclosed. All members' details of the research instruments have been kept anonymous to further ensure their identity does not lead to any patient identification by proxy, even though the research study does not infer patient related data. No organisational, user or patient data has been discussed or used in any form nor recorded in any fashion.

6.4 Summary

This chapter has discussed the chosen research methods and demonstrated that a balance between qualitative and quantitative, in terms of numerical data, can be achieved, while confirming that effective discussion points allow for open-ended and informed views to be made, supported by statistical data obtained from numerical research instruments.

Information constraints can be overcome through probing theories in a relaxed, comfortable and protected environment, while participant empowerment enables ideas to be fully exhausted without criticism allowing for opportunities to be realised which would not otherwise be seen.

In addition, ethical considerations have been discussed in relation to general practitioner's taking part in the study, and what rights they have by doing so.

The next chapter discusses the findings from the data collected, through the use of CAQDAS information tools, which can be further used for emerging analysis to be carried out.

7 Findings & Discussion

7.1 Introduction

This chapter illustrates and pulls together the results from each of the research instruments as outlined in chapter six above, and explains how the data was coded, classified and then used to present them. The data sources comprise of one to one interviews carried out in locations of the participant's choice ensuring a comfortable environment, with a focus group also carried out in a location of their choice where participants felt at ease, and supported by a questionnaire drawing from a wider cohort of GPs.

The findings are themed by: patient accountability, which describes the emerging relationships between patients and doctors, and includes the wider social contract; primary care development, which describes service development direction; NHS restructure, which describes the fall-out from the recent healthcare reforms; and general practitioner qualities, which describe the changing role of GPs.

The chapter concludes with a summary of the emerging themes and how they can be later used to link back to the theory, as identified in chapters two and three.

7.2 Research Cohort

There were a total of twelve one to one interviews, each taking between 45 minutes and 1 hour to complete, and held in a location of the participant's choice, which helped put them at ease during the discussion (Siedman, 2012). Each discussion followed the same research questions, as seen in appendix ten, which would ensure uniformity of data responses. There were seven female GPs and 5 male GPs with their clinical experience ranging from six to forty seven years, while also covering a wide range of business related skills and experience.

Male	5	Between 18 - 47 Years Qualified
Female	7	Between 6 - 34 Years Qualified

Status	
Partner	7
Salaried GP	4
GP Registrar	1
Locum GP	0

The four focus group participants covered a range of management and leadership experiences, from anecdotally acknowledging very little experience to CCG lead member position, although they were all of partner status. The discussion took slightly in excess of 1 hour, and followed the same research questions as the one to one interviews, seen in appendix ten.

Male	2	Between 14 - 25 Years Qualified
Female	2	Between 23 - 24 Years Qualified

Status	
Partner	4
Salaried GP	0
GP Registrar	0
Locum GP	0

The questionnaire was initially sent out to 100 GPs across the North West of England which gave a return of 21 responses. To increase this number the questionnaire was then circulated across a number of additional electronic networks across the UK which brought the final total of responses to 50.

Gender	50*	Between 1 - 40 Years Qualified

* Due to an error with the configuration of survey monkey, the gender question was not available to all participants.

Status	
Partner	42
Salaried GP	6
GP Registrar	0
Locum GP	2

Data from each of the instruments was collected into an electronic format for use with the CAQDAS NVIVO application, (the researcher underwent on-line training to ensure a high level of competence in the use of the NVIVO application) where each of the research instruments was imported as 'source' data, making sure that there were no participant identifiable entries included. The data sources were imported as either textual narrative or dataset types, where the textual narrative was further coded, in context, allowing the forming of 'meaning', with the dataset being used for numerical analysis.

The textual narrative was read through, source by source, where the researcher looked for 'meaning' in the data which was deemed thematic (Boyatzis, 1998), and added to either an existing node of the same theme, if one existed, or by creating a new node. Each of these sources was read through multiple times, allowing a refining of the emerging themes to be developed, with 126 initial themes being created. A further read-through was carried out on the nodes created earlier, again multiple times, to look for further refinement of these emerging themes, which were reduced to a final 16 themes, grouped into 4 areas: Patient Accountability, Primary Care Development, NHS Restructure, and General Practitioner Qualities.

A number of queries and reports were run against each of these nodes to reinforce the researcher's final views which visually/graphically characterise the emerging themes (Boyatzis, 1998), in relation to the purpose of the research study.

7.3 Emerging Themes

Following an iterative process to refine the number of themes identified from the data sources, the following four areas: ***(1) Patient Accountability***; ***(2) Primary Care Development***; ***(3) NHS Restructure***; and ***(4) General Practitioner Qualities***; clearly show a connection to the changes being seen following the current NHS reforms, as described in the five key strategic points seen in Department of Health (2010b); in that, there is a definite drive for ***(1) patients to take control of their own healthcare***; the desire to ***(2) move more care to the community*** from the secondary care sector; how the ***(3) NHS is reorganising the structure between the care sectors***; and how ***(4) General Practitioners Qualities*** can take a leading role within the current changes. However, the emerging themes seen below offer a mix of positive and negative views, indicating further research in each area would be beneficial.

7.3.1 Patient Accountability

A number of comments were made relating to patients taking control of their own healthcare; especially in inner-city locations, with high levels of deprivation and cultural issues, as explained in the comment below, by a participant who is well respected within the GP community and is extremely passionate about the subject.

> *"One of the things that makes people ill is that they don't exercise, they don't exercise because they don't know how, or they're scared to go out, or the facilities aren't very good or they don't encourage young people. So, there are all kinds of impediments which are nothing to do with the health service."*

This is reinforced with this remark, suggesting patients have little or no incentive to take ownership of their healthcare, as described by a senior GP with leadership responsibilities, and who displayed a level of frustration while making the following comment.

> *"People have no incentive to prevent things because they're happy to have their great life, smoke, and drink, do whatever they want – because they know that there will be a health service to take care of them."*

However the present drive to develop services across the community may well enable GPs to configure such services in the future, so as to enable patients to improve their predicament, through such opportunities as explained below by a senior GP also displaying a level of frustration towards the inability to resolve the issue.

> *"There are old people who would be better off wandering down to the cricket club and watching the children play cricket and making the tea than they would be having anti-depressants, but I haven't got a mechanism to do that."*

Although, such a change to healthcare delivery would require the support of all members from within the local community if this is to become a reality, as commented by a senior GP also showing levels of frustration.

> *"And that is to say you can't deliver healthy people by giving them services, you need to do that but you also, like say in [inner city location], we need to bring things together that make people healthy, that includes schools, sports, it includes the environment, the whole community."*

These assertions relate well to the key strategic points of the Health & Social Care Act 2012, as seen in Department of Health (2010b):

- To uphold the existing values and principles of the NHS
- To put patients and the public first
- Improve healthcare outcomes

- Empower professionals with autonomy, accountability and democratic legitimacy
- Cut bureaucracy and improve efficiency

In support of this, the ‘Tag Cloud’ seen in figure 12 below reinforces some of the key words used to describe some of the ‘meaning’ coming from the participants in relation to overall patient care.

Figure 12 – Patient Focus – Tag Cloud

As one would expect, the words *people, doctor* and *caring* show quite predominantly, however the words *change, general, need, now, school, service and time*, could be argued as key terms emerging from the source material used to describe the underlying message that new developments

across the primary healthcare sector are needed to support the transition to a service, where patients participate in their own healthcare, and by including community services in its delivery. In addition, the comments above clearly indicate a level of frustration by the participant GPs, which may become a useful driver for making change.

7.3.2 Primary Care Development

A clear theme that emerged from the research is that GPs agree that the primary care sector needs to change in order to meet the needs of the future NHS, and that in order to do so the methods of delivery must also change. A distinction needs to be made here, in support of the context from the participant responses, that primary care development has two paradigms, (1) the development of the primary care organisations, and (2) the development of the primary care sector. In order to develop the sector, the provider organisations must be capable of offering high levels of care to their patients. The framework presented in chapter 4 supports the development and evaluation of primary care organisations which may also prove useful in the development of the sector.

This theme also appears to be seen as an opportunity to develop primary care in the manner that GPs have previously tried to do, as demonstrated through the following comments, the first by a GP who has a number of years' experience, but will still be facing a long future in the healthcare sector following the outcomes of the current NHS reforms, and who displayed a tone of optimism in relation to the development of the sector.

> *"I think we are at the forefront of it, so we know what patients need, so I think it's a good idea for us to be involved in the decision making".*

And who continues to suggest, in relation to the sector.

> *"but yes, I think we should be, we should be making some of the decisions especially services, which services patients need, and which services patients don't need".*

The following comment came from a senior GP who exhibited a level of frustration towards development of the sector.

> *"Because really I feel we need to massively invest in primary care in this country, but not in primary care as is, we need to massively invest in different ideas and I might come on to what some of those are, but, for example, in [locality] we have this massive trust… It's based on a nineteenth century model, isn't it, of wards? Excuse me, that's how hospitals were invented at the beginning of the nineteenth century… we're now at the beginning of the twenty first century! Is that the way to go forward? No! But where is all our money going? It's going into funding…err… it's all going into a PFI, isn't it? A PFI based around a model of care which is nineteenth century, now that's what I mean it hasn't got any individual underpinning".*

Even if the reforms can overcome some of these frustrations, there remains further scepticism that this opportunity to develop primary care is offered in principle, and that there is no substance to the underpinning support required of government, as described by this GP still facing a number of years within the healthcare sector, and displaying a high level of disappointment.

> *"because I think, everyone I have spoken to, [GP partner] certainly and other people too, say that things happen in cycles and everything seems to go round and round and round".*

In support of these ideas, another common message emerged relating to succession planning, from two perspectives: (1) to provide the energy for GPs to carry out the required changes, and (2) in ensuring these changes remain, into and beyond the next government term. The first comment coming from a

senior GP actively engaged in both the development of the primary care sector, and development of GPs, while talking about leadership.

> *"grow your own, make sure your, especially in [locality], your GPs of the future are gonna have those skills, so that's really important".*

Albeit, with this worried comment from a young GP who is passionate about primary care development.

> *"And I worry about the fact that… there aren't that many young people in the CCG, there aren't that many on the LMC, and where is the generation of [lead GP name]'s generation gonna come from, if you don't grow it?".*

Meanwhile, amongst current debate within the NHS the method of 'federation' remains topical (Ham, Imison, Goodwin, Dixon and South, 2011), although there is concern that the drivers behind the development of federation are not clear. There is concern that government may be driving this method to meet austerity targets, however GPs would much prefer the key driver to be from a clinical/medical perspective, as seen in the comment below, coming from a senior GP exhibiting a level of optimism while also showing caution.

> *"I think, that although we hear about federating practices, I think we can do that… looking at our… I don't know… for example, our… what's the word I'm looking for… kind of our medical behaviour. We can look at how we manage stuff or how we refer stuff and why, and all that kind of stuff".*

And who continues to suggest that.

> *"I think that doing that with your peers is interesting and encourages good practice, but I'm not sure that we can federate in a way that means something… that I think the commissioning people kind of want is that we will see each other's patients freely, I don't think that can happen, but I think that we could commission services".*

Another observation from a young GP who displayed a level of optimism commented.

> *"I think, done in the right way, which I don't have all the answers for – it could well be a good thing for, you know, they used to have things called – collaborations didn't they… they used to have to cover the out of hours and other things like that… within co-operatives you can develop very good local services for the local population".*

In support of the above discussions around primary care development, succession planning and federation, there was a clear message that, for these reforms to be successful there needs to be a clear leadership and management strategy.

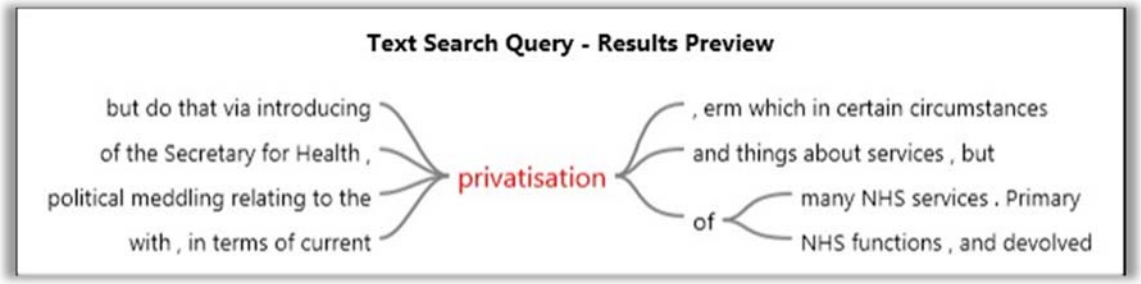
7.3.3 NHS Restructure

Following the Health and Social Care Act 2012, there appears to be a high level of scepticism and mistrust relating to the motives of government, as described by this young GP who still faces a long career within the primary healthcare sector.

> *"in terms of the government's changes, I am exceptionally sceptical of the motives behind the government's changes, exceptionally sceptical behind the; certainly the vast majority of Tory MPs and secondly increasingly since the coalition has formed; all MPs, cause I had held out some hopes that the Liberals would have some sense, which they seem to have lost, so, I am certainly very sceptical; I certainly feel that the underlying motive is to increase efficiency within the NHS; fine, but do that via introducing privatisation, which in certain circumstances can improve efficiency, but I think in a lot of cases just improves private organisations efficiency in making money for themselves, and not necessarily running the NHS efficiently, and I would be wholeheartedly against the changes".*

The issue raised above relating to privatisation appeared a number of times as seen in the word tree in figure 13 below.

Figure 13 – Privatisation Word Tree



In agreement, another frustrated GP continues with the privatisation theme, although shows agreement to the idea of GPs redeveloping clinical pathways.

> *"I think that's the problem with the bill, that I think those enthusiasts or departments desire to save money because they've cut managers by, what is it… about a third or is it two thirds, the cost reduction… so, that's ridiculous because the NHS still needs managing and although clinicians are going to help look at pathways and maybe negotiate stuff, there still needs to be people doing the work, as we found back at base, and I think that's a real… major risk of this bill".*

While, this senior GP asserts further concerns relating to the motives behind the H&SCA 2012, through the following comments.

> *"I think intellectually the Health and Social Care thing is bankrupt, it has no intellectual underpinnings and that is its big weakness, it doesn't have any intellectual underpinnings that relate to the delivery of health care or to the delivery of health, actually!"...*
>
> *"...and the people at the Department of Health know nothing about primary care, they know nothing about general practice but they don't really know what primary care means. Now primary care NHS has*

published on this for decades, you know, it's not rocket science and it's not new, but it's not part of the intellectual discourse in the UK".

As mentioned earlier, there is a continuing message that the NHS is repeating the change cycle, as seen in the following comment from a GP with a number of years experience.

"but the economy is going through a bad cycle too, which hopefully is not going to be ever ending, so hopefully at some point it is going to hit the bottom and then come up again, and if it comes up again then, you know, I am happy to take the rough with the smooth, but if this is it, and this downward spiral continues then I'll definitely look back and wished I'd stayed in hospital rather than be a GP".

This is supported by the following comment from a young GP aligned to organisational leadership development.

"I suppose in terms of kind of innovation, have we seen this all before? So actually has it been like this before, and it has been like this before, in certain ways in the… PEC days because [senior GP] used to go through kind of like a lot of history of commissioning with me in the PEC days, and fund-holding feels relatively similar, doesn't it in some ways".

This senior GP sums up the general feeling about the H&SCA 2012 through the following comment.

"and the thing that frightens me most about the changes at the moment is I think there is a lot about general practice which is very, very, very good and I think that the model that we've had over the years is actually a very good model in terms of doctor patient relationship and proving that level of trust and that level of care and that level of commitment that really things like the Francis report have shown is sadly lacking and I'm really frightened that things may change".

It can be seen that the implementation of the H&SCA 2012 has stirred up many emotions, right across the age range of GPs where it is still to be seen if those new challenges can to be accomplished.

7.3.4 General Practitioner Qualities

When discussing leadership and management in terms of business qualities, GPs appear to have mixed feelings. Put quite simply, they are either not interested in business whatsoever, or there appears to be a misunderstanding between two perspectives, (1) looking at business skills relating to primary care organisations, and (2) looking at business skills relating to the primary care sector.

This message comes through quite clearly from the study which suggests that from the research cohort, GPs are first and foremost clinical, and traditionally have no or little interest in business leadership and management, especially from an NHS perspective, as can be demonstrated from the following comment from a GP, who appeared to be apathetic while talking about this topic.

> *"but as a business I think that we are not really the best people to run a business, because we are; what's the word; empathetic, we care for the patients, that's what a GP is, a GP is caring, it's a caring profession, so we would prefer to do things that would help the patients and not our pockets".*

This view is supported by the following comment from a GP, who came across as agitated towards this topic.

> *"I hate that sort of area to be honest, I am far happier and feel more comfortable making clinical decisions about patients than I do trying to decide what service to provide because it's a LES and we'll get paid for this-that-and-the-other, and trying to configure our service so that we*

can stay afloat because payments are being eroded left right and centre".

This decision to shy away from business can also be seen in terms of natural aversion, which can be seen through the following comment from a GP, who incidentally has since become a GP partner.

"I specifically chose to work at [practice name], a student practice in [locality], because I wanted to be a salaried GP, and I did not want any of the business responsibilities because I knew I didn't have any of those skills".

It is acknowledged however, that there are some GPs who hold an interest in business leadership and management, as seen in the comment below, from a senior and respected GP.

"I think most GPs are not business minded and would prefer to be in a salaried position, although a few would prefer to be the entrepreneurial type… to generate income, employ other salaried GPs, build up large amounts of income and so on, It's not what drives me particularly"...

..."I don't think most would welcome it, either… some might… there are some GPs that do MBAs, but most would want the life of a salaried GP without the hassle of, you know, worrying about income, and QOF, and paperwork, and this and that – that's what they moan about, but they're very reluctant to let go of their independent contractor status, which seems very bizarre to me, you either want to be one or the other… if you want to be the King Pin in an entrepreneurial practice, and make loads of money… then that's fine… but if you do that and then moan about having to see patients and do paperwork and worry about QOF and looking for other income streams… well, don't do it…. do something else".

Therefore, in terms of partners, who have legal responsibilities and duties as business owners, a conflict is created with their lack of interest in the topic. An explanation may arise from the comments below which highlight the past limitations to job status, as described by a senior GP.

> *"Well at the time that was the only thing… to be a GP, was to be a partner"...*
>
> *..."Well when I first took it on I was a single handed GP in a group with other GPs, so the issue of partnership didn't really come up until I then joined with another doctor, we went for a two person practice, and I didn't really… that's the way it was… I didn't really think of it as a partner".*

With another similar remark, as described by another senior GP.

> *"Yeah, yeah it was that way round, yeah… it was definitely… I wanted to be a GP, but when I was looking for general practice there was no such thing as a salaried partner, there was no such thing… basically… There were partnerships or you locumed and there was nothing in between".*

For those GPs who do have an entrepreneurial capability, their motivation can also be put into question as can be seen from the comment below.

> *"and I think if, if it is a major decision part, then I would question their GPs ability to be a good GP, maybe they're a good entrepreneur, and there are all sorts of GPs that have setup businesses and out of hours services and this-that-and-the-other, maybe they're good GPs too, I don't know but they're certainly good entrepreneurs, I am not convinced that they all go hand-in-hand".*

However, once the idea of entrepreneurialism is related to clinical innovation, there appears to be a shift in acceptance of that capability, as seen in the comment below, albeit prompted by the researcher.

> *“looking after patients… incidentally the business gets brought along with that… so you’re entrepreneurial drivers are really health related”...*
>
> *...“Oh yes, I’d agree with that… yeah, because I think between us we have the skills to manage a small business and… but I wouldn’t have thought about it in that way”.*

The following remark may be seen as somewhat controversial, but appears to fit with the emerging message, taken from a senior GP.

> *“I think the future NHS in primary care needs to revisit the independent contractor status and maybe even get rid of it, but assuming, we can’t get rid of it, because I think they’re the biggest obstacles to change, that’s my personal view. We need to redevelop a primary care that’s much more sensitive to the needs of patients rather than the desires of entrepreneurial GPs to generate an income”.*

This leads on to the issue of workload, which comes through as an important problem facing the current NHS reforms, described here by a GP expressing an air of discontentment.

> *“I think GPs are increasingly overworked and under recognised, and less and less well remunerated and certainly at the moment it looks like all of those aspects are getting worse, so at the moment it is going through a bad cycle”.*

Again, explained through this comment by another GP, who although coming across as optimistic, still appeared concerned with this matter.

> *“I think the trouble is at the moment GPs are so pressurised… I mean… colleagues that I meet on the training group and so on… people who are very experienced, who I could look up to and think I*

> *would like to be like that, they seem to be getting pretty hacked off and talk about how they're working harder than they did before".*

The following observation highlights one of the key issues facing the NHS, in terms of leadership, as seen in this comment from a senior GP.

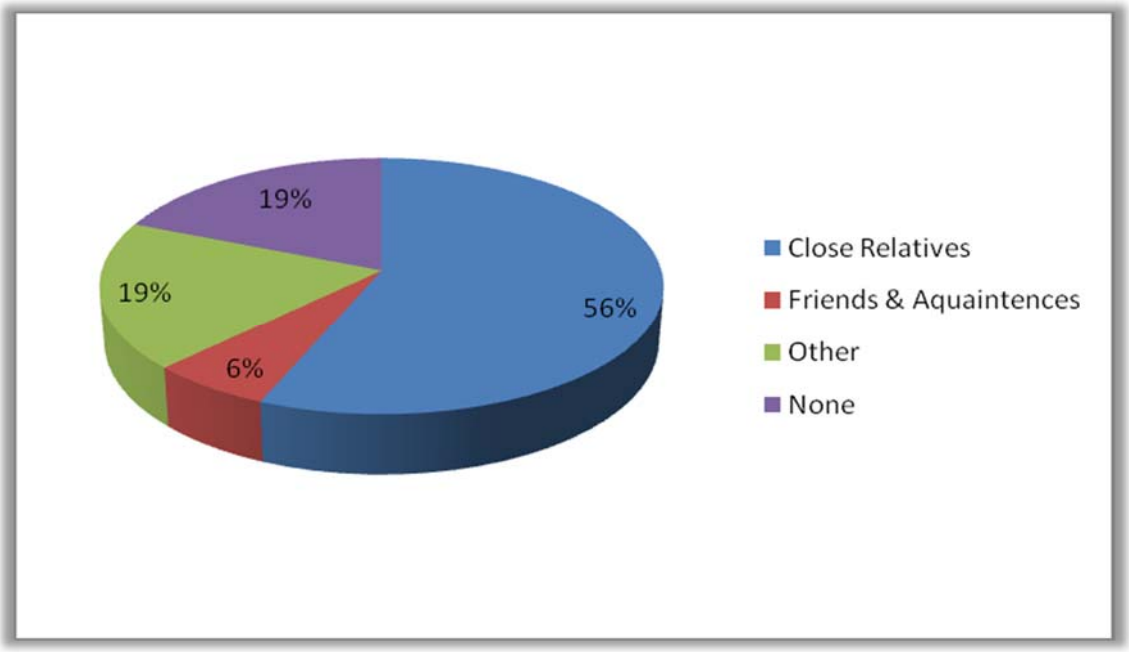
> *And I think a lot of practices… a lot of GPs… are too busy doing the doing, they're happy like the hamster going around the wheel and they haven't had the opportunity to step off and look at what's going on and think 'actually – could we do this differently, could we do this better, and work smarter?'*

It can be seen from the comments so far that GPs have little interest in business leadership and management, and appear to have taken on the role of business leader, in terms of partnerships, without really considering their obligations, but possibly driven on by the opportunity to ensure autonomy. Instead, they have fully focussed on their clinical skills and healthcare delivery to patients within the primary care sector, following an altruistic behaviour.

The general feeling of altruism and autonomy appear to run throughout these themes, which suitably directs the research findings to those of a more personal nature, which may help understand how GPs have come to demonstrate such characteristics.

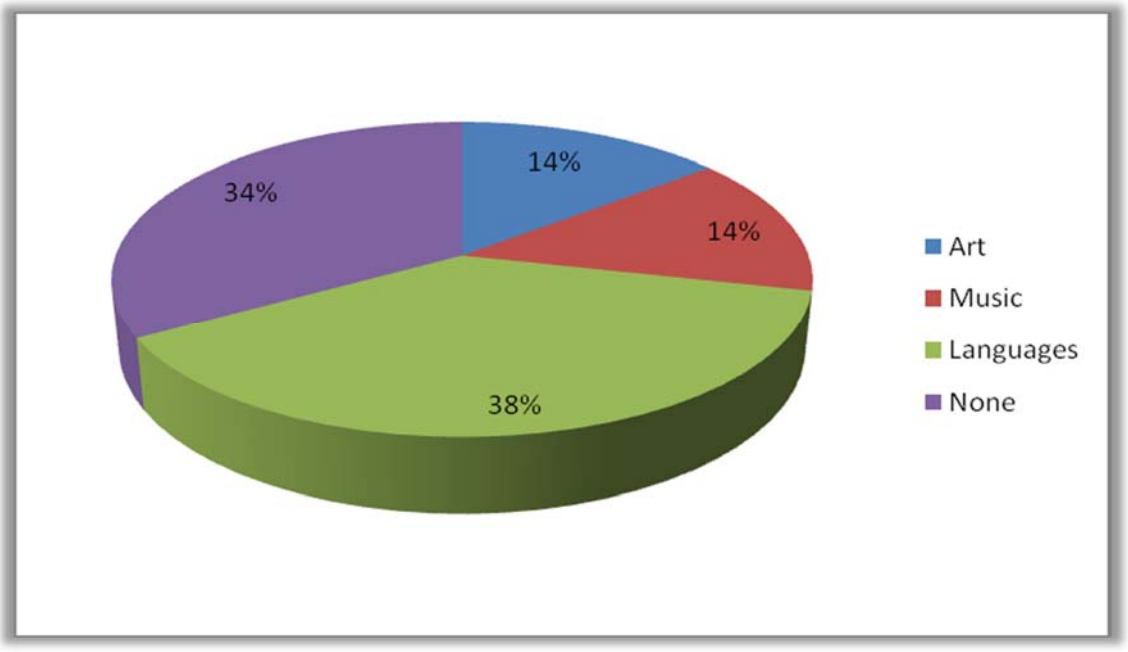
An observation worthy of note identified from the research data that **31.25%** of GPs noted their parents as being teachers, and having some influence over their decision to become a GP.

Figure 14 – Influence to Become a GP



The full ratio of influences can be seen in figure 14, which shows that close relatives have a significant share of influence.

Figure 15 – Arts & Languages



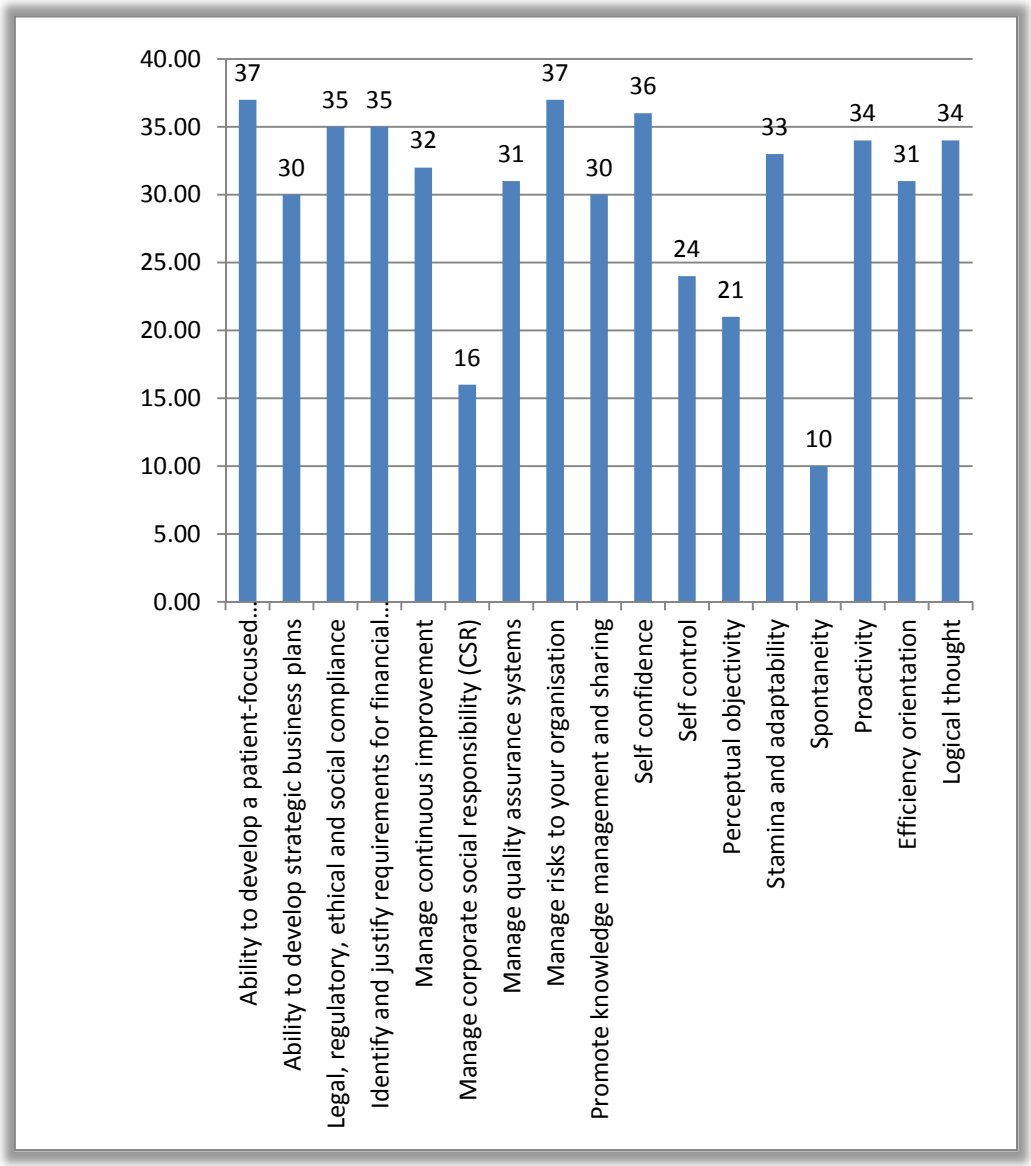
In addition, it can be seen that GPs, despite being essentially scientifically minded, have a creative side to their character as seen in figure 15, which shows 38% enjoying languages and 28% enjoying the act of art or music.

Please note the percentages are based upon all the participants excluding those from the questionnaire, and with some GPs accounting for more than one item.

7.4 Numerical Analysis

In addition to the thematic analysis as seen above, as part of the questionnaire research method (50 participants), GPs were asked to confirm which business related qualities they felt are essential for GPs to meet the NHS outcomes framework, which can be seen in figure 16 below.

Figure 16 – Business Related Qualities



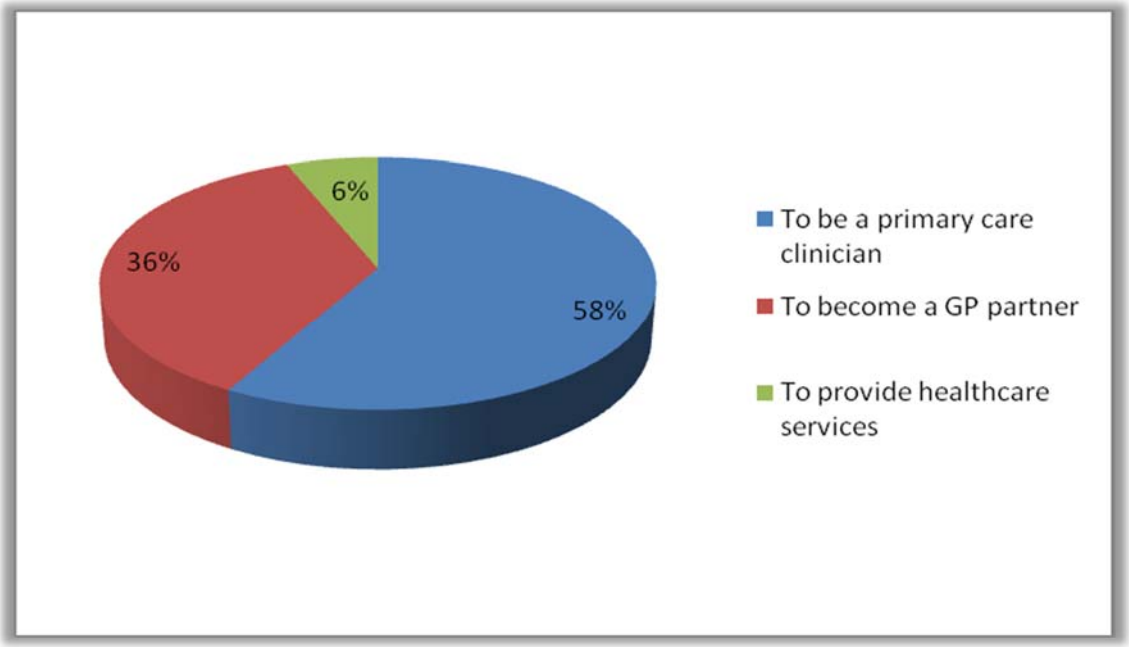
It is interesting to see that only 32% (16) of GPs feel that they should manage Corporate Social Responsibility (CSR). This may prove to be an indicator for GPs reluctance to participate in business issues from a ‘sector’ perspective, even though CSR should sit at all levels of business.

Spontaneity received 20% (10) of GPs, which may indicate their perceived reluctance to be classified as entrepreneurial, although this could also be argued as relating to their ‘conditioning’ to follow pre-defined pathways.

As expected, the ability to develop a patient-focussed organisation returned one of the highest scores at 74% (37), with manage risks to your organisation sharing the top score at 74% (37).

From the questionnaire cohort, 58% (29) of GPs chose to become a GP to be a ‘primary care clinician’, with 36% (18) choosing to become a ‘partner’, leaving 6% (3) of GPs choosing to ‘provide healthcare services, which can be seen in figure 17 below.

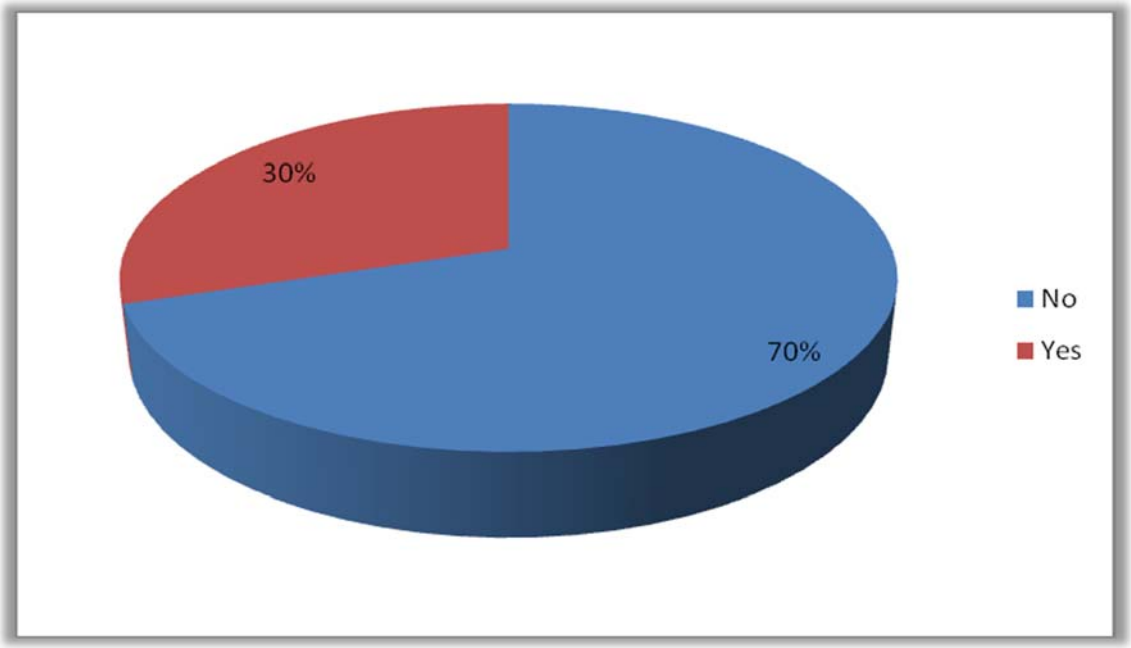
Figure 17 – Reason to Become a GP



Of the 36% of GPs who chose to become a ‘partner’, it is unclear as to the level of understanding they had towards their obligations as business owners, which would certainly benefit from further research.

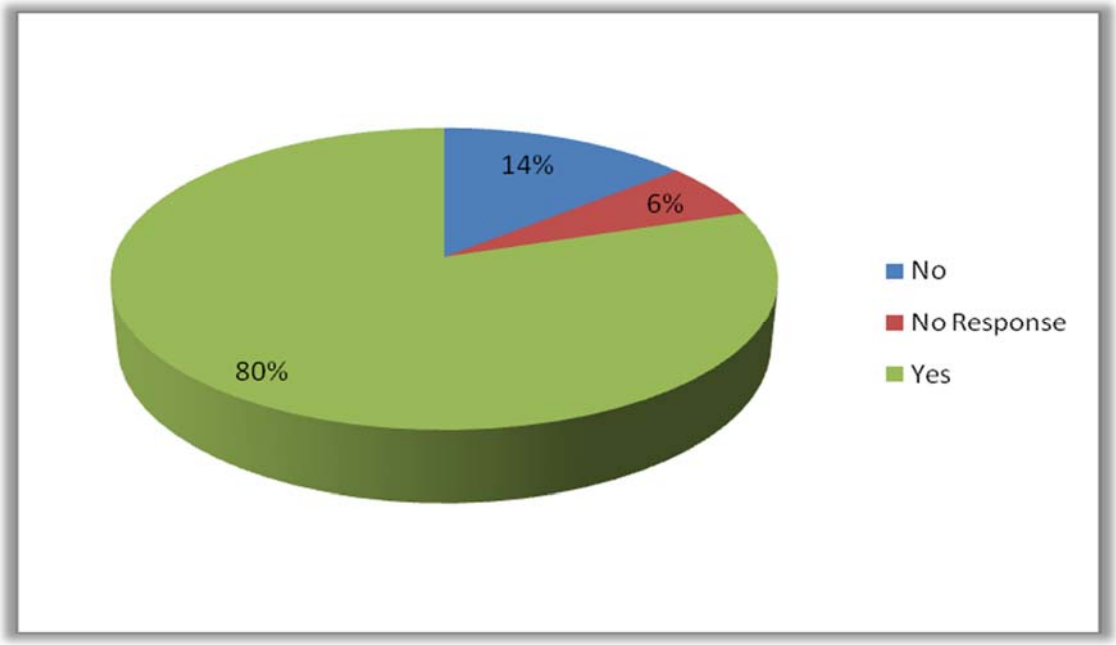
GPs were also asked if they had considered the need for business skills when deciding to become a GP, as seen in figure 18 below.

Figure 18 – Business Skills Prior to Becoming a GP



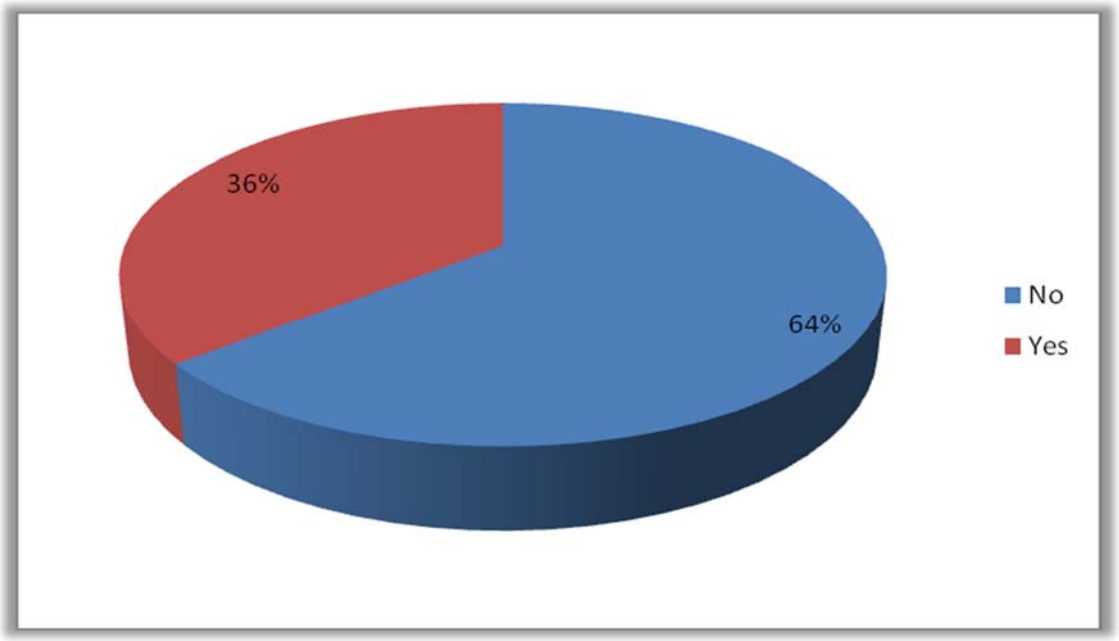
It can be seen that 30% (15) of GPs had considered the need for business skills, with 70% (35) having no consideration.

Figure 19 – Business Skills Since Becoming a GP



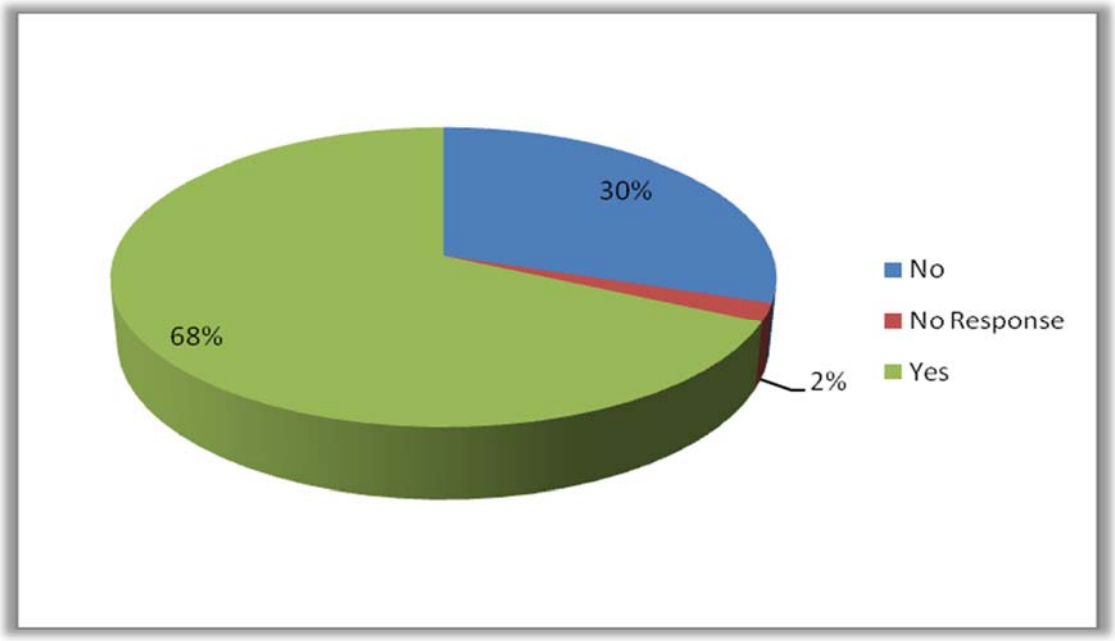
It can be seen from figure 19, that since becoming a GP, a considerable amount of GPs 80% (40) have considered the need to undertake business training.

Figure 20 – Undertaken Business Skills



Although 80% of GPs have considered to undertake business skills training, as seen in figure 19, only 36% (18) of GPs have actually undertaken some sort of business skills training, leaving 64% (32) opting to continue without, as seen in figure 20.

Figure 21 – Business Skills Required for NHS Outcomes Framework



When asked if business skills are required to deliver the NHS Outcomes Framework, 68% (34) of GPs agree, with 30% (15) disagreeing, leaving 2% (1) GP not responding.

These statistics could be argued as indicating that GPs agree they need business skills training to meet the H&SCA 2012, and are reluctantly open to engaging in some sort of training.

7.5 Summary

This chapter has discussed the findings from the research methods in terms of common themes emerging from the qualitative thematic analysis with numerical data in support of it.

The findings are presented through the interpretation of the researcher's view of the data in context with the specific objectives of the research study. A significant element to this research is based around the qualities that GPs

have and/or need in their role in the delivery of 21st Century healthcare from a business perspective.

It can be seen from the comments above that there appears to be a mix between frustration, optimism, scepticism and trust in taking forward the government's plans.

The next chapter analyses and draws conclusions from the findings, while attempting to link these conclusions back to the theory discussed in earlier chapters.

8 Analysis & Conclusions

8.1 Introduction

The findings seen in the previous chapter offer a number of insights into how the objectives of this study may be better understood, and which will also aid in the answering of the research question:

> ***What management and leadership qualities would enable primary care GPs to deliver "The Operating Framework for the NHS in England 2012/13, and beyond"?***

This chapter draws on these findings and aligns them to the key messages emerging from related theory.

The themes taken from the research study are directed towards the concept of GPs functioning as business leaders in addition to their clinical role, albeit dependent upon their organisational status, while making sense of how common qualities between the two functions of business leader and clinician are related, in terms of the congruence of GPs acting as business leaders determined in relation to the primary healthcare sector.

Interpretation of these findings is derived from the researcher's point of view, although a steadfast attempt has been made to remain unbiased. Being a qualitative study, this analysis is presented in narrative form as opposed to a scientific report, where each of the four objectives and research question will be determined.

It is hoped that the outcomes of this chapter will be used to inform and inspire further related research.

8.2 Research Objectives

Arguably, the Health and Social Care Act 2012 (Department of Health, 2012a) has brought about the most significant change to UK healthcare since the inception of the NHS in 1948. The clear directive to move the bulk of patient care from hospitals to primary care organisations, led by GPs (Department of Health, 2011), underpins the objectives of this research which relates to the qualities required of GPs as business leaders in order to meet these new demands.

The researcher focuses attention on how much consideration GPs give to business leadership when choosing to become a GP; how much consideration they give to business related education; their understanding of how business skills can improve employability; their understanding of how business skills can improve NHS services; and the identification of what qualities are required of a modern GP/GP Partner.

These results are interpreted through the narrative drawn from the qualitative data, supported by the numerical data obtained in the study.

8.2.1 GP Consideration of Becoming a Business Leader

From the findings it can be seen that doctors spend a considerable amount of time educating themselves in the subject of medical practice, and although a small proportion have preconceived ideas to become a GP, many do not. It is suggested that doctors tend to not consider becoming a GP until they have completed their medical training, where they then face the choice to either remain a hospital doctor, to become a hospital consultant/specialist, or to become a general practitioner.

Once they have made the choice to become a GP, the options available to them traditionally were partner or locum status only (Laing, Marnoch, McKee, Joshi and Reid, 1997) although today there is the additional option of salaried GP (including assistant status). The reason for only having the option to

become a partner or locum has not been covered fully in this study and would benefit from further research. However, from the anecdotes, themes and literature emerging from the study, it can be assumed that the limitation can be attributed to insistence of early GPs wanting to retain their independence when first agreeing to join the NHS at its inception in 1948, (Westland, Grimshaw, Maitland, Campbell, Ledingham and Mcleod, 1996).

It could be argued that over time, and supported by anecdotes from the study, that this independence has underpinned what we now term as ‘GP autonomy’ to such an extent that even today, when choosing to become a GP they appear to aspire for partnership status solely to ensure this is achieved. The role of a salaried GP is therefore perceived as having less autonomy due to their employed status, and many newly qualified GPs suggest they intend to work on a salaried basis for a short period while they obtain experience, and still ultimately desire the role of partner. GP autonomy can be qualified through Furnham, Crump and Chamorro-Premuzic (2007) work around Expressed Inclusion of senior managers, articulated in terms of their comfortable and confident manner in clinical decision making and assuming responsibility, which may be deemed unattainable under an employed status.

Given the decision to become a GP partner is premised upon achieving full autonomy, in terms of their clinical ability, which is also deemed to reinforce reputation as a product of that autonomy, it therefore fits with what Borgatti and Halgin (2011) describe as ‘choice’ and ‘success’ outcomes, where choice includes behaviours, attitudes, beliefs and structure, and where success includes performance and rewards as a result of those choices. With these outcomes taking precedent, little consideration is given to their role as business leaders, further indicating the drivers for partnership status are personal reputation and reward, in terms of clinical achievement, rather than entrepreneurial success.

Because ‘choice’ and ‘success’ appear to be the main drivers for GPs, then the NHS may well benefit from the creation of ‘very senior’ posts, for example; Clinical GP Director, GP Consultant, or GP Specialist Practitioner. As long as

these posts can offer full autonomy, articulated through Furnham, Crump and Chamorro-Premuzic (2007) suggestion of Expressed Inclusion, then GPs may be open to giving up their independent contractor status, allowing for entrepreneurial individuals to take over the running of primary care organisations; in terms of expressed business leaders.

8.2.2 GP Consideration of Business Related Education

Further supporting this lack of consideration of business leadership when choosing to become a GP, may well come from there being little opportunity for GPs to commence as a ‘start-up’ in today’s NHS; therefore GPs have little need, and appear to prefer the joining of an existing partnership in the knowledge that somebody else will already have the abilities to run a small business and feel comfortable in disregarding this until later, while giving the opportunity to learn these skills on-the-job. This supports the work of van der Velden (2012) who asserts that education should develop independent critical thinkers, who are able to direct their continuous learning when required; in terms of GP business skills training, they have the capability to learn business related skills while on-the-job (Allen, 1995; Gattrell and White, 1996; Ong and Schepers, 1998).

Learning on-the-job comes through clearly in the data where prior to becoming a GP, 70% of questionnaire participants gave no consideration to business skills training, yet since becoming a GP, 80% of questionnaire participants considered undertaking business skills.

However, it can be seen from newly qualified GPs and those currently in training that business leadership is emerging as a more important skill, and is increasing its place in educational curriculums, although this still has some way to go (Ham, Dixon and Brooke, 2012; Kings Fund, 2013).

Beside the need to learn business skills for local organisational purposes, there appears to remain a high level of distaste towards business skills training, in terms of being used by government to redevelop the primary care

sector. This feeling was clearly seen from the study that GPs believe their clinical skills are better used for patient care than for business reorganisation, and their time should not be wasted on government (re)positioning, and vote collecting, where government are seen to use such measures in terms of monitoring patient satisfaction (Department of Health, 2012d).

8.2.3 Understanding How Business Skills Improves Employability

Responding to the NHS reforms, GP practices have become members of clinical commissioning groups (CCGs) where collectively they cover a much wider patient list size, and are therefore seen as a major player in the delivery of healthcare services in comparison to hospital trusts, mental health trusts and social care organisations (Department of Health, 2012a).

The role of general practice as a member of their CCG, requires many strategic decisions to be made, and as a result, general practice are looking to the obtaining of relevant skills through their GP partners, albeit reluctantly as described in the previous section. Therefore, as partnership positions become available, anecdotally due to the older generation of GPs despondently leaving the profession, prospective partners are asked to bring such skills. This explains two observations from the findings: first that existing GPs have no desire to obtain business skills to meet the demands of government, and secondly explains the perceived increase in business skills delivered to newly qualified GPs.

The practice augmentation of new GPs with these skills joining the partnership, and acting as a practice representative at CCG level, supports Lewis (2012) who suggests that GPs need to find ways of communicating across boundaries through the concept of work-role transition, and through Atkin and Hassard (1998) notion of ‘communal belonging’ for the assessment of solidarity across institutions.

8.2.4 Understanding How Business Skills Improves NHS Services

Over time it may well be seen that government achieve their sector redesign, influenced through the development of individuals participating in CCG activities, as CCG structures strive to include personal development plans for their active members. However, this would also enable those member GPs to further develop their business related skills in relation to their own organisations, although this in turn supports primary care commissioning objectives, therefore seen as a win-win situation.

When considering business skills, a distinction must be made between those skills required to run a small business – general practice, and those required to commission services – CCG. Although it could be argued that both require a similar skill set, there is a feeling within the findings that general practice looks at ‘local’ operational levels of business management and leadership, and that CCG looks at ‘sector wide’ strategic levels. This emerges from the findings through the idea that general practice exists to meet patient demand and has no perceived competition requiring little strategic thinking, while CCGs as commissioners are strategically looking to find efficiencies in healthcare delivery.

General practice through their participation as member practices of CCGs have two roles; member of the CCG as commissioner, and provider organisation offering primary healthcare services. It is these two opposing positions that GPs consideration of business skill set differs. They accept that they must learn how to run a small business in terms of operational objectives, but are disdainful in developing business skills to run a CCG. The feelings coming from the findings show that GPs consider themselves medical practitioners delivering great patient care and not entrepreneurial business people looking for financial efficiencies.

However, in support of Abbott, Proctor and Iacovou (2008) view that ‘Alliance’, referring to arrangements between multiple primary care organisations in the form of GP commissioning groups or locality groups, proves to be the most

successful management engagement mechanism when planning local initiatives, from an organisational perspective. These general practice business skills enable general practices to participate in local opportunities, whether as part of federation, GP Provider Organisation (GPPO), Limited Liability Partnership (LLP) etc, or directly for the practice in terms of developing income streams. However as a result, through practices participating in such ‘group’ activities, then this would enable CCG’s to conceivably deliver better healthcare to the community, through economy of scales.

The redesign of NHS primary care is taking shape irrespective of GPs views, where there is an underlying realisation that if GPs do not respond to these sector changes, then somebody else will do it for them. It is this concern that engages GPs in starting to respond to the idea of holding business skills for sector reasons, and can be seen by practices retaining new partners with these skills to reinforce their position. This further supports the use of the derived framework as seen in chapter 4 which aids in the monitoring of skills across the organisation, and supports development of those areas the partnership is lacking.

8.3 Answer to the Research Question

The significant changes brought about by the recent NHS reforms as asserted by Department of Health (2012a), has exposed two paradigms of primary healthcare business management and leadership; the first related to general practice – ‘provider’, and the second related to the CCG – ‘commissioner’. This is complicated by the need for GPs to act on behalf of both paradigms at the same time causing a conflict of interests.

Understanding the qualities required of GPs to meet these demands, as posed by the research question, seen below, is of paramount importance to both paradigms.

What management and leadership qualities would enable primary care GPs to deliver "The Operating Framework for the NHS in England 2012/13, and beyond"?

The qualities required of GPs related to general practice are complicated and fraught with confliction, as 'providers' of healthcare general practice must demonstrate the ability to offer high quality healthcare to their patients, while the qualities required of GPs as members of the CCG, in terms of 'commissioners' of those services, must demonstrate efficiency and value for money. Importantly, it is required at all times that they must show due diligence in relation to conflicts of interest.

General practice organisations are required to hold membership with a CCG to meet their contractual requirements, and all GPs aligned to that practice (including regular locum GPs) are expected to participate in membership decisions; therefore it could be argued that all GPs must have some level of business management and leadership ability, if only to understand and participate in the decisions being made by the CCG membership (Department of Health, 2010b; Department of Health, 2011; Ham, Dixon and Brooke, 2012).

It can be seen from the findings of the research study that GPs see the need to hold business skills as partners within their own organisations as a necessary evil, but see the need to hold these same skills for their membership of the CCG as unnecessarily imposed. However, in order to help understand these needs the qualities framework seen in figure 22 below should aid GPs in their planning of 'qualities' attainment applied to either role.

The derived qualities and domains as described in section 4.2.3 above are presented in a framework format below, where each of these qualities can be rated as basic, intermediate or advanced for each domain. A set of competencies support each domain in relation to each quality, where an individual can rate themselves as basic, intermediate or advanced for each competency within that scorecard. By totting up the competencies on the

scorecard the count should indicate the overall rating of that quality, and should be recorded on the framework, as seen below.

Figure 22 – Qualities Framework

EXAMPLE MATRIX *(of how an individual may map themselves)*

DOMAIN	QUALITY					
	Behaviour, Attitude & Belief	Knowledge & Understanding	Performance	Self Image	Skill & Dexterity	Social Responsibility, Ethics & Principles
Analytical Ability	Basic	Basic	Basic	Advanced	Intermediate	Basic
Developmental Capabilities	Intermediate	Intermediate	Basic	Advanced	Intermediate	Basic
Innovation & Creativity	Intermediate	Intermediate	Advanced	Intermediate	Basic	Intermediate
Leadership	Basic	Intermediate	Advanced	Intermediate	Intermediate	Intermediate
Manage Self	Advanced	Intermediate	Intermediate	Advanced	Advanced	Advanced
Quality	Advanced	Advanced	Advanced	Advanced	Advanced	Advanced
Shared Values	Intermediate	Intermediate	Advanced	Intermediate	Intermediate	Intermediate
Strategist	Advanced	Intermediate	Intermediate	Intermediate	Advanced	Advanced
Working with others	Basic	Advanced	Advanced	Advanced	Advanced	Advanced

When planning the desired level of attainment, individual GPs and those who are part of multi-partner general practice should consider each quality (as defined in section 4.2.3) in relation to the corresponding domain, in context to the competency (as seen in section 4.2.3) they are expected to hold for the function they will be performing, although this process is best considered by the leadership team, who can align the desired competencies to the organisational strategy for each individual in a jointly constructed understanding of the organisational needs. However, models of management & leadership can be scoped through the use of this framework where desired qualities can be mapped for personal development, which underpins Boyatzis (1982) view that participants must understand the intentions behind the model, to be seen as useful. So for each function a GP is expected to carry out, they can rate themselves on the competency scorecard as described above and map to the framework in relation to that function and expected outcomes.

When mapping these qualities as part of a multi-partner general practice, an assumption is made that understanding, significance and meaning are developed as a whole, and that these experiences are socially constructed, and are accepted as an objective reality in the construction of knowledge (Andrews, 2012).

Through consideration of primary care ‘provider’ needs, the mapping of qualities may well be different from the mapping against CCG ‘commissioner’ needs, which fits with Mumford and Gold (2004) opinion that organisational-specific models provide specific management development needs. This is also true when mapping the needs of a number of individuals systemically as described by Tate (2013), who suggests that strategy must fit throughout the organisation, and individuals make up component parts of that strategy. Therefore, by mapping the functions to the framework, and the GPs to functions, an overall strategic fit may be seen.

It may now be argued that the qualities required of GPs in the delivery of the NHS Outcomes Framework (Department of Health, 2011) can be met through competency attainment in terms of functions required of organisational strategic models, identified through the use of the qualities framework, while noting where certain competencies may be transferrable from existing skills.

As the listed competencies have largely been derived from other existing frameworks, each of the competencies listed against each domain would benefit from further research, to specifically identify how each competency adds value to its domain, while in addition further research is required into the application of the derived qualities framework to fully test its applicability to general practitioners would prove useful.

8.4 Summary

This chapter has drawn conclusions from the findings of the study to help develop the answers to the objectives and research question outlined in chapter one while relating these results to the theory identified in the literature.

By gaining a thorough understanding of the topic, the objectives and research question have been interpreted by the researcher to reveal that most GPs traditionally do not consider their role as business leaders when choosing to become a GP, and do not consider business education as part of their future career path, however there is some emerging desire to obtain business skills by newly qualified GPs to improve their employability while existing GPs appear to be responding to the current changes in the primary healthcare sector by developing their business leadership skills, albeit some are doing so due to need rather than desire.

The researcher has also introduced a primary care specific ‘qualities framework’ with supporting competency mapping scorecards which may be used to help GPs develop their business management and leadership skills, derived from a number of pre-existing frameworks identified from the literature.

The next chapter takes a look at the entire study and reflects on how this was carried out, while noting any contributions to knowledge that can be seen as a direct result of this research project.

9 Reflection & Contribution to Knowledge

9.1 Introduction

The previous chapters have identified and answered a number of objectives relating to the perceived qualities required of modern general practitioners in order for them to lead the NHS in the delivery of the NHS Operating Framework (Department of Health, 2011). This chapter reflects upon the research methods and the findings as a result of that research by noting some of the key findings and how they relate to the overall research objectives.

It also reflects on the development of a qualities framework for use by GPs in relation to business and leadership, through the mapping of qualities against a number of domains measured by competencies, and how this may be used to support individual or organisation wide educational strategies.

A selection of observations identified by the researcher during this study is made, with further reflection given to the adopted approach and to the limitations of the study, with some overall recommendations made in terms of the implementation plan of the qualities framework.

In addition, a number of areas have also been identified which would benefit from further research.

The chapter concludes with a section looking at perceived contribution to knowledge and practice, which completes this research study.

9.2 Reflection

The chosen research topic came about through the researcher's role in the strategic management of primary healthcare organisations and coupled with the recent NHS reforms. It was realised that significant change to how primary healthcare organisations are run, is required. Through tacit knowledge and emerging literature (Ham, et al., 2011; Kings Fund, 2013) it was identified that

the most notable constant throughout the previous 65+ years of the NHS was the role of GPs as contractors, and hence the researcher decided to study this area further. Upon reflection it appears that change to this constant may well be the one activity that realises a significantly different change to the NHS than seen in previous attempts.

By bringing together all of the smaller primary care organisations under the control of a central leadership and management structure may well support the release of many GPs from their responsibility as business leaders and allow them to continue in their chosen clinical career path, while allowing the more entrepreneurial of GPs to take up the remaining leadership and management roles may well offer the efficiencies needed to meet the needs of the NHS. Throughout this study a number of related observations have been seen; the most significant is where GPs have been placed in a position where they are naturally conflicted in terms of being providers to the healthcare sector, yet influence commissioning of services through their membership of CCGs. It could be argued that government have managed to manipulate the Health and Social Care Act so that GPs have no choice in taking on this position, with a view to drive GPs towards opting out of their contractual responsibilities.

Another observation which has yet to be seen in its totality is that a significant amount of healthcare staff have been moved out of the NHS towards private organisations, which passes the immediate problem of ‘efficiency realisation’ away from current political measures, but will likely have a considerable negative effect on future NHS financial management in the form of negative equity in pension funds; this will certainly demoralise GPs.

Throughout this study it can be seen that GPs are animated about the change to a clinically led NHS, but are uninterested in the organisational structure behind it, which is something that mirrors the findings of the research methods where GPs are largely uninterested in becoming business leaders, and do so purely to attain autonomy.

9.2.1 Critique of Adopted Approach

The approach to this research was influenced by the nature of the study being that of, one's (GP) interpretation of actions, therefore aiming to understand phenomenon, where such research lends itself to qualitative methods. The qualitative methods adopted offered a broad range of data, and coupled with the use of thematic analysis through the use of the NVIVO application gave a clear presentation of the data.

By taking an inductive approach requiring the researcher to act as an insider caused some challenge in terms of objectivity, which necessitated a strict attitude to the study and being a single researcher added to this challenge. However, this inductive approach taking an insider stance enabled the study to uncover elements of the research topic which allowed the researcher to establish coherence and congruence.

Through the outcomes of this research it can be seen that the research question has been answered which further reinforces the chosen approach. A logical progression from question to method to discussion can be seen, and although a number of areas for further research have been uncovered, there are no questions left unanswered.

9.2.2 Limitations of the Study

In an attempt to gain support within the sector, this research study only sought the views of GPs, where it would have been useful to seek views from other allied professionals who could have offered a different perspective to how GPs perform as managers and leaders. Also due to time constraints, limitations to the research instrument development was seen, which specifically may have benefitted by additional pilot tests to uncover any inconsistencies in the interview question wording, which in practice required the researcher to clarify further for a number of participants.

9.2.3 Recommendations and Implementation Plan

It is recommended that what has been learnt from this study, in relation to GP personal qualities and through the derived qualities framework, is taken to implement an educational strategy which underpins the needs of General Practice to participate in the delivery of new services to the health of the nation.

The qualities framework will be introduced to the researcher's area of practice, closely linked to organisational strategy through general practice engagement mechanisms already in place.

9.2.4 Opportunities for Further Research

The literature review process looked at a number of broad areas covering the life of GPs in anticipation that the research would uncover specific areas of interest. In addition to those intended, a number of additional areas have been identified for further research, such as: *'people in specialist technical roles tending to be treated in a senior capacity, although typically having poor management and leadership skills'* (Furnham, Crump and Chamorro-Premuzic, 2007), where it is worth noting that GPs carry out specialist roles, therefore does this mean they are inherently less likely to hold the capability to offer good management and leadership? and that '*value and skill outweighs knowledge, even though it is largely accepted that knowledge underpins skill*' (Wickramasinghe and De Zoyza, 2009), where it is also worth noting that the GP role is based upon knowledge, so does that mean that GPs are less likely to hold high values?

It could be suggested the study could have narrowed its field of research and still gained an understanding of the research objectives; however without such a broad review, it can be argued that these areas for further study would not have been identified, and would not have influenced the development of the qualities framework.

The qualities framework seen in appendix twelve may yet prove valuable to primary healthcare educational strategies as GPs respond to the NHS reforms, although further research would prove useful in its delivery and application to practice. The framework is further supported in appendix thirteen and fourteen.

Other areas that would benefit from further research are: '*gaining a better understanding of the obligations GPs have as business owners and their perception towards it'* (Renton and Watkinson, 2001; Webster, 2005) as seen in Coulson-Thomas (2009)*;* and *'why there has been a limited offer of roles to GPs to only include the form of partner or locum, until recently'* (Laing, Marnoch, McKee, Joshi and Reid, 1997); and in relation to the primary healthcare sector: *'how will patients take future ownership of their own healthcare'* (Keaney, 1999)?

9.2.5 Publishing Plans

Following completion of this research study (expected late 2013), the researcher plans to submit abstracts relating to the implementation of the derived qualities framework to the British Medical Journal (BMJ) and the Health Service Journal (HSJ), in the first instance, for submission in upcoming issues during 2014.

The researcher will also seek opportunities to further promote this study at future relevant conferences such as British Academy of Management (BAM), Chartered Management Institute (CMI) and Capita Conferences to aid in further awareness.

9.3 Perceived Contribution to Knowledge and Practice

Drawing from the research study it can be seen that a number of findings have been identified which have captured several key themes, such as: the lack of GP consideration to become business leaders; primary healthcare leading change as a result of the Health and Social Care Act 2012; the need

for a refinement of educational strategies to support the future of primary care; and the need for patients to take ownership of their own healthcare. Through the use of the derived qualities framework, GPs are now able to identify their specific business leadership competency needs in relation to their own organisations, and that of their respective CCG. The framework also allows for a systemic view to be adopted, while supporting further development of modern educational strategies.

The qualities framework could also be adapted for use by the wider organisational team where it may prove valuable to extend this research from understanding the business skills of General Practitioners to understanding the business skills of General Practice, as many practices look to engage managing partners who are not GPs, as the realisation of such voids takes hold.

The study specifically offers a contribution to knowledge through an established line of theory relating to GP qualities and the relationship these have with development of primary care. In addition a contribution to knowledge can be seen in relation to organisational and educational strategies in support of the Health and Social Care Act 2012. A further contribution to knowledge can be seen through the identification of the lack of information supporting existing GP business and leadership skills.

As a result of this, it is hoped this research study leads to further research in general practitioner business leadership and educational strategies.

9.4 Summary

This chapter has reflected upon the research study methods, and considered the perceived contribution to knowledge seen as a result. It has considered the reasons for undertaking this research study and through its delivery has both answered the research objectives, and identified a number of areas which would benefit from further research.

A brief explanation of the depth of the study was given, which ultimately led to the answering of the research question:

> ***What management and leadership qualities would enable primary care GPs to deliver "The Operating Framework for the NHS in England 2012/13, and beyond"?***

The value of the qualities framework was noted along with a summary of other areas which would benefit from further research. In addition a number of observations were given as a by-product of the research study.

A critique of the adopted approach has been given with a number of limitations to the study, followed by the perceived contribution to knowledge and practice which covered the development of the qualities framework, and how it may be applied to GPs, and potentially to other professional cohorts. This chapter now completes the research thesis in partial fulfilment of the requirements of the University of Chester for the degree of Doctor of Business Administration.

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Appendixes

Appendix One – The Nolan Principles

THE SEVEN PRINCIPLES OF PUBLIC LIFE

SELFLESSNESS

Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

INTEGRITY

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

OBJECTIVITY

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

ACCOUNTABILITY

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

OPENNESS

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

HONESTY

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

LEADERSHIP

Holders of public office should promote and support these principles by leadership and example.

These principles apply to all aspects of public life. The Committee has set them out here for the benefit of all who serve the public in any way.

Appendix Two – NHS Constitution Principles and Values

PRINCIPLES

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. NHS services must reflect the needs and preferences of patients, their families and their carer's.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public, communities and patients that it serves.

VALUES

1. Respect and dignity.
2. Commitment to quality of care.
3. Compassion.
4. Improving lives.
5. Working together for patients.
6. Everyone counts.

Appendix Three - General Practice Evolution

Source: Laing, Marnoch, McKee, Joshi, and Reid (1997)

Appendix Four – NHS Leadership Framework

Seven facets of the Leadership Framework

- Leadership Framework (LF)
  - 1.0 Demonstrating personal qualities
  - 2.0 Working with others
  - 3.0 Managing services
  - 4.0 Improving services
  - 5.0 Setting direction
  - 6.0 Creating the vision
  - 7.0 Delivering the strategy

Appendix Five – Medical Leadership Competency Framework

Domain	Elements
Demonstrating personal qualities	Developing self awareness
	Managing yourself
	Continuing personal development
	Acting with integrity
Working with others	Developing networks
	Building and maintaining relationships
	Encouraging contribution
	Working within teams
Managing services	Planning
	Managing resources
	Managing people
	Managing performance
Improving services	Ensuring patient safety
	Critically evaluating
	Encouraging improvement and innovation
	Facilitating transformation
Setting direction	Identifying the contexts for change
	Applying knowledge and evidence
	Making decisions
	Evaluating impact
Creating the vision	Developing the vision for the organisation
	Influencing the vision of the healthcare system
	Communicating the vision
	Embodying the vision
Delivering the strategy	Framing the strategy
	Developing the strategy
	Implementing the strategy
	Embedding the strategy

Appendix Six – Personal Style Assessment

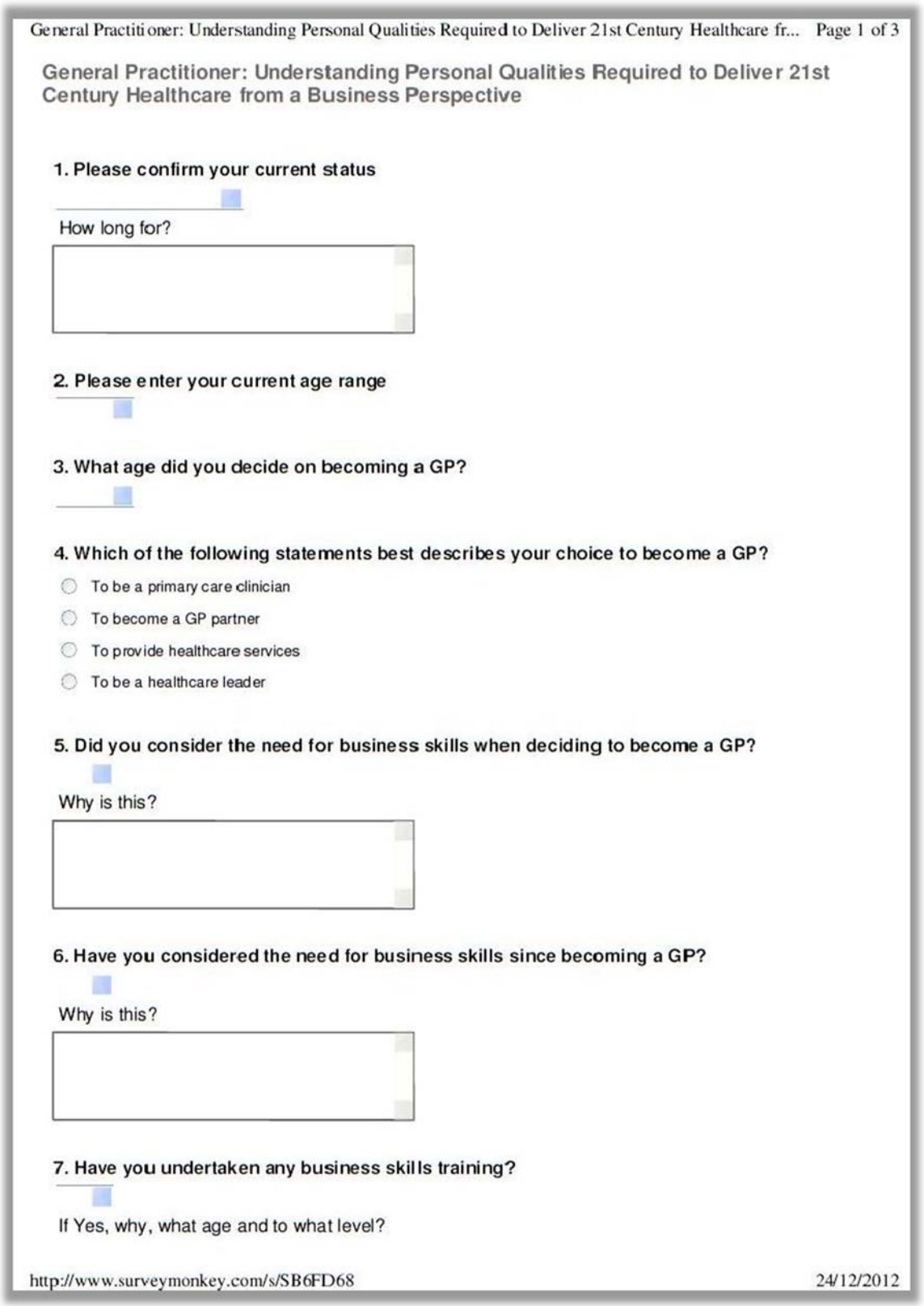
Appendix Seven – Excellence in Management and Leadership

Appendix Eight – NOS Competency Standards

Standard	Ref	Standard	Ref
Standard Description	TEST	Standard Description	TEST
Manage yourself	CFAM_LAA1	Develop and sustain collaborative relationships with other departments	CFAM&LDD3
Develop your knowledge, skills and competence	CFAM_LAA2	Develop and sustain collaborative relationships with other organisations	CFAM&LDD4
Develop and maintain your professional networks	CFAM_LAA3	Manage conflict in the broader work environment	CFAM&LDD5
Lead your organisation	CFAM&LBA1	Lead meetings to achieve objectives	CFAM&LDD6
Provide leadership in your area of responsibility	CFAM&LBA2	Represent your area of responsibility in meetings	CFAM&LDD7
Lead your team	CFAM&LBA3	Identify and justify requirements for financial resources	CFAM&LEA1
Evaluate your organisation's operating environment	CFAM&LBA4	Obtain finance from external sources	CFAM&LEA2
Develop your organisation's vision and strategy	CFAM&LBA5	Manage the use of financial resources	CFAM&LEA3
Develop strategic business plans	CFAM&LBA6	Manage budgets	CFAM&LEA4
Promote equality of opportunity, diversity and inclusion	CFAM&LBA7	Provide healthy, safe, secure and productive working environments and practices	CFAM&LEB1
Develop your organisation's values and culture	CFAM&LBA8	Obtain physical resources	CFAM&LEB2
Develop operational plans	CFAM&LBA9	Manage physical resources	CFAM&LEB3
Manage risks to your organisation	CFAM&LBB1	Manage the environmental and social impacts of your work	CFAM&LEB4
Develop, maintain and evaluate business continuity plans and arrangements	CFAM&LBB2	Optimise effective use of technology	CFAM&LEB5
Manage corporate social responsibility (CSR)	CFAM&LBB3	Promote knowledge management and sharing	CFAM&LEC1
Ensure compliance with legal, regulatory, ethical and social requirements	CFAM&LBB4	Manage information, knowledge and communication systems	CFAM&LEC2
Identify and evaluate opportunities for innovation and improvement	CFAM&LCA1	Manage knowledge in your area of responsibility	CFAM&LEC3
Plan change	CFAM&LCA2	Communicate information and knowledge	CFAM&LEC4
Engage people in change	CFAM&LCA3	Use information to take effective decisions	CFAM&LEC5
Implement change	CFAM&LCA4	Decide whether to produce or buy in products and/or services	CFAM&LED1

Evaluate change	CFAM&LCA5	Procure products and/or services	CFAM&LED2
Plan the workforce	CFAM&LDA1	Select suppliers through a tendering process	CFAM&LED3
Recruit, select and retain people	CFAM&LDA2	Outsource business processes	CFAM&LED4
Induct individuals into their roles	CFAM&LDA3	Implement and evaluate strategic business plans	CFAM&LFA1
Manage the redeployment of people	CFAM&LDA4	Implement operational plans	CFAM&LFA2
Manage redundancies	CFAM&LDA5	Manage business processes	CFAM&LFA3
Initiate and follow disciplinary procedures	CFAM&LDA6	Manage programmes	CFAM&LFA4
Initiate and follow grievance procedures	CFAM&LDA7	Manage projects	CFAM&LFA5
Build teams	CFAM&LDB1	Develop understanding of your markets and customers	CFAM&LFB1
Allocate work to team members	CFAM&LDB2	Develop marketing plans	CFAM&LFB2
Quality assure work in your team	CFAM&LDB3	Implement marketing plans	CFAM&LFB3
Manage people's performance at work	CFAM&LDB4	Manage the development of products and services	CFAM&LFB4
Manage team communications	CFAM&LDB5	Manage the marketing of products and services	CFAM&LFB5
Support remote/virtual teams	CFAM&LDB6	Bid for contracts	CFAM&LFC2
Manage flexible working	CFAM&LDB7	Sell products and services	CFAM&LFC3
Manage conflict in teams	CFAM&LDB8	Develop a customer-focused organisation	CFAM&LFD1
Promote staff wellbeing	CFAM&LDB9	Deliver products and services to customers	CFAM&LFD2
Identify individuals' learning needs and styles	CFAM&LDC1	Manage customer service	CFAM&LFD3
Support individuals' learning and development	CFAM&LDC2	Manage quality assurance systems	CFAM&LFE1
Mentor individuals	CFAM&LDC3	Manage quality audits	CFAM&LFE2
Coach individuals	CFAM&LDC4	Prepare for and participate in quality audits	CFAM&LFE3
Help individuals address problems affecting their performance	CFAM&LDC5	Carry out quality audits	CFAM&LFE4
Develop and sustain productive working relationships with colleagues	CFAM&LDD1	Manage continuous improvement	CFAM&LFE5
Develop and sustain productive working relationships with stakeholders	CFAM&LDD2		

Appendix Nine – Questionnaire



General Practitioner: Understanding Personal Qualities Required to Deliver 21st Century Healthcare fr... Page 1 of 3

General Practitioner: Understanding Personal Qualities Required to Deliver 21st Century Healthcare from a Business Perspective

1. Please confirm your current status

How long for?

2. Please enter your current age range

3. What age did you decide on becoming a GP?

4. Which of the following statements best describes your choice to become a GP?

- To be a primary care clinician
- To become a GP partner
- To provide healthcare services
- To be a healthcare leader

5. Did you consider the need for business skills when deciding to become a GP?

Why is this?

6. Have you considered the need for business skills since becoming a GP?

Why is this?

7. Have you undertaken any business skills training?

If Yes, why, what age and to what level?

http://www.surveymonkey.com/s/SB6FD68 24/12/2012

8. In order to deliver the NHS outcomes framework, do you feel that it would be beneficial if GPs held business and management skills?

Why?

9. Please confirm which of the following business related qualities you feel are essential for GPs to meet the NHS outcomes framework. (Select all that apply).

- Ability to develop a patient-focused organisation
- Ability to develop strategic business plans
- Ensure compliance with legal, regulatory, ethical and social requirements
- Identify and justify requirements for financial resources
- Manage continuous improvement
- Manage corporate social responsibility (CSR)
- Manage quality assurance systems
- Manage risks to your organisation
- Promote knowledge management and sharing
- Self confidence
- Self control
- Perceptual objectivity
- Stamina and adaptability
- Spontaneity
- Proactivity
- Efficiency orientation
- Logical thought

10. If there is anything else you feel may be relevant, please comment here.

Done

Appendix Ten – Researchers Interview Guide

1) **Please discuss your childhood; did you know what you wanted to be/do, at an early age?**
    a. **Were there any others in your family/friends who were GPs/Doctors?**

    Researcher Note: Start the discussion by asking the interviewee to reflect upon their child hood and any influences there may have been that aided in their decision to become a doctor/GP.

2) **Please discuss your school years; did you consciously follow an educational pattern to help you achieve becoming a GP?**

    Researcher Note: Follow this by discussing their education/schooling. Did this enable/support their pathway to becoming a doctor/GP.

3) **Please discuss your doctor training; when did you decide you wanted to be a GP?**

    Researcher Note: Once at med school, did they plan to become a GP? If so, what influences were there, and what drove them on?

4) **Please discuss your GP training; did you consider your role in a small business, other than that of a doctor?**

    Researcher Note: Discuss their GP training; did they consider their role (responsibilities – employee, legal, economic) as a partner in a small business, or did they simply see a partnership as a way to maximise their income?

5) **Please discuss; during your time as a partner, have you developed your role as a business person? And if so, have you considered yourself to be entrepreneurial?**

    Researcher Note: Once they were practicing as a GP, was there any realisation that they were 'in-business' and as a result did they consider their 'entrepreneurial' view/position?

6) **What is your view on the recent H&SC Act 2012, in terms of GP businesses?**

    Researcher Note: As the health and social care act comes into force, what is their view on how GPs and their businesses will meet the demands of moving the focus of care to the community?

7) **If you had the choice, would you follow the same journey again?**

    Researcher Note: If they were to take the same journey again, are there anv other considerations/reflections that thev think mav contribute to the

Appendix Eleven – Participant Information Sheet

Nature of the research

The purpose of this research is to identify what management and leadership qualities would enable primary care GPs to deliver "The Operating Framework for the NHS in England 2012/13, and beyond".

The research will be carried out by the researcher alone.

The research is not funded or sponsored, and is being carried out as part of the fulfilment of a doctoral degree in business administration, on behalf of the University of Chester.

It is the intention that all participants shall be general practitioners, although at different stages of their careers.

Requirements of taking part

The participants are asked to reflect upon their education, choice to become a GP, and any consideration towards business management and leadership. The data collected will be of a qualitative nature requiring further analysis at a later time.

The data will be collected via questionnaires, focus groups and one to one interviews.

Questionnaires are likely to take less than 10 minutes to complete, with focus groups taking between 45 minutes and 60 minutes, depending upon participant availability. One to one interviews are also likely to take approximately 45 minutes.

All data is expected to be collected by the end of May 2013, although focus group and interviews are expected to be completed by the end of April 2013.

Implications of taking part and participants' rights

All participants will be informed of their choice not to take part, and that their participation is purely on a voluntary basis.

If there are any questions that the participant is uncomfortable in answering they do not have to give an answer, and no inferences will be taken.

Permission will be sought to record the discussions prior to commencement.

Participants have the right to withdraw from the study at any time, and for their data to be discarded.

There are no perceived risks to taking part, and the researcher confirms that no data will be shared for any reasons.

The use of data collected and the way in which it will be reported

Only the researcher and the participant will have access to the data.

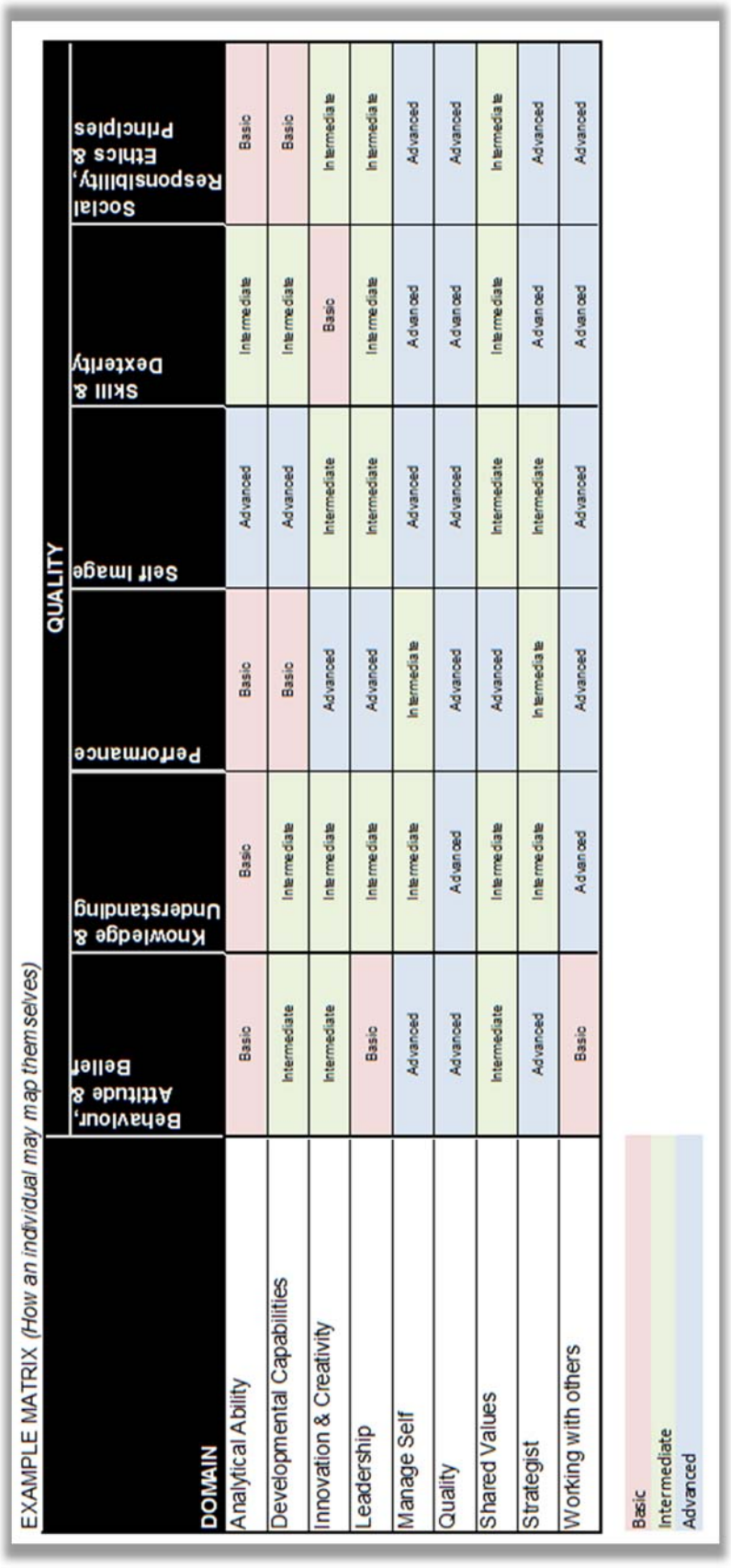
Any data used within the final analysis will continue to be completely anonymised.

Upon completion of the research study, all source data will be deleted.

Contact details for further information

For further information please contact the researcher on the contact number given separately. If you require a response from an alternative source, then please contact the faculty of business enterprise and life-long learning at the University of Chester.

Appendix Twelve – Qualities Framework



EXAMPLE MATRIX *(How an individual may map themselves)*

DOMAIN	QUALITY					
	Behaviour, Attitude & Belief	Knowledge & Understanding	Performance	Self Image	Skill & Dexterity	Social Responsibility, Ethics & Principles
Analytical Ability	Basic	Basic	Basic	Advanced	Intermediate	Basic
Developmental Capabilities	Intermediate	Intermediate	Basic	Advanced	Intermediate	Basic
Innovation & Creativity	Intermediate	Intermediate	Advanced	Intermediate	Basic	Intermediate
Leadership	Basic	Intermediate	Advanced	Intermediate	Intermediate	Intermediate
Manage Self	Advanced	Intermediate	Intermediate	Advanced	Advanced	Advanced
Quality	Advanced	Advanced	Advanced	Advanced	Advanced	Advanced
Shared Values	Intermediate	Intermediate	Advanced	Intermediate	Intermediate	Intermediate
Strategist	Advanced	Intermediate	Intermediate	Intermediate	Advanced	Advanced
Working with others	Basic	Advanced	Advanced	Advanced	Advanced	Advanced

Basic
Intermediate
Advanced

Appendix Thirteen – Qualities Summary

QUALITIES

Behaviour, Attitude & Belief – [Quality]
Such qualities stem from an individual's concept of themselves, which should be aligned to the perception of others, in terms of how they apply themselves to the task in hand, in line with the shared values of the group/organisation.

Knowledge & Understanding - [Quality]
This refers to an individual's capability to understand the details of a task which falls out from their knowledge of the theory supporting it, as a result of human values and interests.

Performance - [Quality]
The ability to demonstrate positively the adequacy of one's competencies while organising tasks in relation to the organisational plan.

Self Image - [Quality]
The personal interpretation of how one perceives them self in relation to shared values within their organisation, and premised upon their own beliefs, and those of their peers, and subject to one's own opinion and judgement of their own personality.

Skill & Dexterity - [Quality]
Having the ability to understand theory and technique while problem solving organisational issues.

Social Responsibility, Ethics & Principles - [Quality]
Understanding the issues and accepting accountability for those issues relating to the wider context of society while obtaining appropriate consent/informed consent; not entering into deception; protection of participants; and offering debriefing and confidentiality.

Appendix Fourteen – Domain Summary

DOMAINS

Analytical Ability – [Domain]
The ability to analyse organisational activities and impact, underlies all other domains, in that desired outcomes must be met within the operating framework of the organisation to maintain stability and viability. Individuals at all levels should have the capability to contribute to this domain.

Developmental Capabilities - [Domain]
Each organisation, should have a vision, and mission to achieve that vision. The developmental domain is used to ensure the preparedness of the organisation to execute the mission.

Innovation & Creativity - [Domain]
Following the typical life cycle of products and services, organisations would benefit from continued innovation and creativity in the development of new and emerging products and services, sometimes termed '*in the pipeline*'.

Leadership - [Domain]
All organisations require a leader, with a number of leadership styles to choose from (with the exception of a few, such as co-operatives etc, but these will not be discussed here, as outside of the scope of this project). However, leadership may not be one single person, as in the typical configuration of primary care organisations, there is likely to be several as part of a partnership. Systemic leadership implies a number of participants are involved with organisational leadership where each will take ownership of certain tasks, and therefore may need to achieve advanced levels in particular competencies and only a basic understanding in others.

Manage Self - [Domain]
This domain covers both the individual and the needs of the organisation, in terms of person fit. When delivering a strategy all individuals will take an operational share, and their fit has far reaching consequences, as their actions are interdependent upon other individual's actions.

Quality - [Domain]
This domain covers how an organisation carries out its functions, in that these functions are both safe and efficient. Effective quality processes can considerably improve productivity and return on investment (ROI).

Shared Values - [Domain]
High quality organisations look to the sharing of values across the whole team to limit conflict and achieve a high level of coexistence.

Strategist - [Domain]

All good leaders have the ability to envision the aims of their organisation. GPs as leaders of primary care organisations must now look to envision their organisational fit to the new and emerging NHS. Development of an understanding of future developments of the NHS would benefit primary care organisations and help ensure their survival.

Working with Others - [Domain]

Understanding key stakeholders is crucial to any organisation, such as patients (in terms of healthcare), staff, suppliers and partner organisations.